DEPARTMENT OF

HEALTH SERVICES STUDIES

Tata Institute of Social Sciences

CONFERENCE ON

STRENGTHENING OF HEALTH RESEARCH

IN NON - GOVERNMENTAL ORGANISATIONS

IN INDIA

November 14th and 15th, 2003

at Homi Bhabha Centre for Science Education, Mumbai.

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CONFERENCE ON STRENGTHENING OF HEALTH RESEARCH IN NON-GOVERNMENTAL ORGANISATIONS IN INDIA

Supported by :

Tata Institute of Social Sciences, Mumbai

In partnership with

BAIF Development Research Foundation, Pune

Child In Need Institute, Kolkata

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Preface

The project on "Strengthening Health Research in Non-Governmental Organizations in India" is one of the 10 international awards given by the Rockefeller Foundation, New York to support cooperation in health research for development. This project was one among the 10 projects selected from 542 proposals received from 83 countries. The Project envisaged to develop research skills in 15 health NGOs, so that these health NGOs can make use of research for their programme planning to deal with priority health problems. To achieve this, the whole research process was demystified and simplified in such a way that the health NGOs can assimilate these skills easily. The Project did not select potential health NGOs but adopted a self-selection strategy, through which the health NGOs who are committed and interested in research entered the health research network.

At the end of the Project, 36 health NGOs had successfully went through the research capacity development process and had prepared their research report for implementation. They had prepared their action plan based on the research findings, which would be implemented in the near future.

In this Conference, these health NGOs would be presenting their research findings and action plan for discussion. These 36 research papers are divided into five Conference sessions, viz. (i) Child Health and Nutrition, (ii) Adolescent Health, (iii) Women's Health, (iv) Communicable diseases and (v) Non-communicable diseases. The whole Project is a success because of the relentless efforts made by these health NGOs in participating in all the activities of the Project and finally coming out with the research paper. I would like to congratulate and thank them for their tremendous contribution to the Project.

The outcome of the Project in these 3 years is the teamwork of 5 partner institutions, viz. (i) Sree Chitra Tirunal Institute for Medical Sciences and Technology, (ii) BAIF Development Research Foundation, (iii) Institute of Health Management, (iv) Child in Need Institute and (v) Tata Institute of Social Sciences. I would like to thank the head of these institutions to participate in this Project by way providing the valuable time of their staff as resource persons. Ultimately, it was the team of resource persons from these partner institutions worked relentlessly to develop the research skills in health NGOs. I am grateful to these team members whose contribution to the Project was critical for the success.

I would like to thank the Advisory Committee Members: Prof. P. Ramachandran, Dr.Sulochana Abraham and Dr. Vijay Aruldas for their valuable advice and guidance all through this project. Prof. P. Ramachandran

was not only the Advisory Committee member but also an active resource person all through the project. He prepared the research methodology manual titled, "User Friendly Survey Research and Statistics for Health Workers: A Primer", which was extensively used by the health NGOs in developing research skills. I thank him profusely for his contribution to this Project.

I take this opportunity to thank on behalf of the partners the Rockefeller Foundation, New York for selecting this Project among the 542 proposals received from 83 countries. I hope that we have justified our selection by successfully completing this Project. We would also like to thank the RPC/EIP of the World Health Organization in Geneva for providing technical support to this Project.

After this Conference, we would like to come out with a publication of the Conference proceedings along with the final version of the full research papers, and the details of the implementation of the action plan. We also plan to develop the research manual into a research methodology textbook for health workers and hope to publish through a commercial publisher. Therefore, this Conference is critical for the Project and everyone's input and feedback will go a long way in bringing out a meaningful document on research capacity development of health NGOs.

Dr. C.A.K. Yesudian
Professor and Head
Department of Health Services Studies
Tata Institute of Social Sciences

14th November 2003

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Section I : An Overview of the Project

Dr. C. A. K. Yesudian

AN OVERVIEW OF THE PROJECT

Dr. C.A.K. Yesudian

Introduction

Normally research is considered as a complex intellectual exercise, which generates knowledge in a particular area of study. Thus research remained in the domain of academicians and other researchers. Of late, application of research methodology has been widened and simplified to make use of it for programme planning, management, monitoring and evaluation. But all these activities are carried out by specialists in these areas. Therefore, these specialists are appointed by different organizations to perform the role of researchers. Those who are working at the grass-roots level have to depend on these research specialists to plan, manage, monitor and evaluate their projects systematically. If research methodology can be simplified and demystified, these functions of the specialists can be better performed by many non-governmental organizations (NGOs) working at the grass-roots level. Simplified and demystified epidemiological and social science research can help health NGOs to plan programmes and strategies and implement them properly. If field level experiments and innovations are linked with proper research framework, the development of the innovative programmes and strategies would be more effective and its impact and change can be measured and documented easily.

Keeping the abovementioned points in mind, the action research project in the field of community health was formulated. The objectives of the action research project are as follows:

1. To develop capacity in NGOs to undertake epidemiological and social science research and to make use of the findings of the studies for planning health care programs.
2. To provide technical assistance to the NGOs to develop research as part of the health care program and to translate research into action (action research)
3. To develop skills within the NGOs to monitor and evaluate their health care programs.

The project proposal envisaged to develop research capacities in 15 health NGOs.

Partnership

The action research project was carried out by five partner institutions. They were,

1. Tata Institute of Social Sciences, Mumbai

2. Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
3. BAIF Development Research Foundation, Pune
4. Child in Need Institute, Kolkata
5. Institute for Health Management, Pachod

The first two partner institutions are academic institutions specializing in social science research and epidemiological research respectively. The other three institutions are large health NGOs who have a wide network of contacts with smaller health NGOs and they also have good experience in field research. The partnership was formed to bring together the experience and expertise of these institutions to develop the research capacity of the health NGOs.

Health NGO Network

The partners met together for the first time in Mumbai (Bombay) on 26th February 2001 to chalk out a strategy to create a network of health NGOs. The partners discussed on 2 options to create the network. The first option was to identify directly 15 well-known health NGOs, who have the potential to undertake research. The second option was to spread a wide net initially to identify a very large number of health NGOs and study their characteristics, potential and willingness to participate in the Project. Those who were interested could be called for a preliminary workshop on health research to asses their interest to develop research capacity. This strategy focused on smaller health NGOs who have interest of commitment to develop research rather than having research potential. The partners opted for the second strategy and decided to work with a large number of small health NGOs, all of whom might not complete the research capacity exercise, but would gain some health research skills.

To implement the decided strategy to create the Network, initially a list of health NGOs was prepared from various sources such as Voluntary Health Association of India, Christian Medical Association of India, Catholic Health Association of India and BAIF Development Research Foundation. The list consisted of 2667 health NGOs. A two-page questionnaire was mailed to them enquiring about their programmes and their interest in joining the Project. In all 517 health NGOs responded to the questionnaire. The questionnaire enquired about their infrastructure and staff and their interest to participate in the Project. A detailed questionnaire was sent to these 517 health NGOs with the purpose to assess their current research capacity. 208 health NGOs responded to the questionnaire. The questionnaire enquired about their research infrastructure such as computer, internet and e-mail facilities and staff having research capacity. Further,

the study explored the previous experience in research, their areas of research interest, and previous training in research.

It was found that 65 percent of the health NGOs did not have any research experience. Of those health NGOs, who had undertaken research, 70 percent did not use the findings of the research in their programmes. Most of them undertook the research in the form of baseline surveys or evaluation studies to fulfill the requirements of the donors. The database generated out of the questionnaire was placed in the website of the Project, www.healthresearchnetwork.org. Thus a Health NGO Research Network was formed with 208 health NGOs.

Planning Research Capacity Development

Having formed the Network, the partners started thinking about the strategy to implement the research capacity development plan. Since these health NGOs had very little research knowledge and skills, it was decided to break the whole research process into small modules. It was decided to create 7 modules to cover the whole research process. The partners wanted to impart the 7 modules in 4 training workshops. After each training workshop, the health NGOs could be sent back to implement the module. Thus, by breaking the research process into small and simple steps, the health NGOs would be comfortable to assimilate the research skills.

A survey research manual titled, "User Friendly Survey Research and Statistics for Health Workers: A Primer" was prepared. This primer explained the steps in research in simple terms with suitable examples. A copy of the manual was given to the health NGO as a reference book.

From the beginning, the partners decided that no money would be transferred to the health NGOs for conducting research. But all their expenses to attend the training workshops would be taken care of by the Project. Further, they would be given free computer services for data processing and analysis. On the part of health NGOs, they had to make copies of the interview schedule or questionnaire. Since the project involved developing research capacity, the partners decided to insist the health NGOs to train their field staff for data collection and not to appoint field investigators only for the purpose of this Project.

Preliminary Phase

The partners decided to invite the 208 health NGOs of the Network for a preliminary workshop called

Research Development Workshop. The purpose of the workshop was to expose the health NGOs to action research and to help them identify a research problem concerning their field programme.

These workshops were organized in the partner institutions in different regions of the country. It was a four-day workshop orienting the health NGOs to identify the research topics, research objectives, variables for each objective and the source of information for the variables. The workshop started with orientation of using research for health development. This was followed by the presentation of the partners about their experience in action research. Each one presented a live example of using research for health development. Then they were oriented to identify a research problem, its objectives, variables and source of information. This was followed by group work, in which the health NGOs met in small groups and discussed their programme concerns to identify a research problem. Then in the plenary, they presented their research problems with justification. The partners as resource persons further helped them to refine their research problems and to identify the research topic. Then a group of health NGOs worked under the guidance of a partner and prepared the objectives, variables and the source of information. This was presented in the plenary session on the last day. The programme of the workshop is given in Appendix-1. At the end of the workshop, all the participating health NGOs were asked to submit a preliminary research proposal for considering them for further research capacity development. In all, 8 workshops were held between April and June 2002 and 157 out of 208 health NGOs attended the workshops (see Appendix-2).

Selection of Health NGOs for Research Capacity Development

One hundred and two preliminary research proposals were received. Two proposals were received in vernacular language. Since they were instructed to submit in English and the whole process of research capacity development was in English, these two proposals were rejected. Remaining 100 preliminary proposals were evaluated based on the topic identified, objectives set-up for the topic, variables identified for each objective and the source of information for each variable. Maximum of two marks were allotted for the research topic, five marks for research objectives, five marks for variables and three marks for source of information. A maximum of 15 marks were allotted for each proposal.

Two of the partners evaluated each proposal independently and gave the marks. Then the partners met together and shared the score. When there was a variation of 5 marks between the 2 evaluators of the same proposal, the proposal was gone through by other partners and a consensus was arrived at. Only 3 proposals had to undergo this process. The two scores awarded to each proposal were added and the total

was arrived. Then all the proposals were ranked based on the total score. It was decided that those who had scored 60 percent or 18 marks out of 30 marks and above would be included for the second module workshop. In all 57 proposals were selected.

Research Proposal Writing Workshop

All the 57 successful health NGOs were invited for a 6-day workshop on Enhancing Research Capacity of Health NGOs in different partner institutions. The objective of this Workshop was to prepare a detailed research proposal and the tools of data collection, so that the health NGOs could go for data collection immediately after the Workshop. The six-day programme is given in Appendix-3.

On the first day of the Workshop, the health NGOs worked with a partner as guide and corrected their preliminary research proposal prepared in the first workshop. At the end of the first day, a lecture on steps in preparing research proposal was given by one of the partners. Second day onwards, they started working on research methodology. They worked with their guides and prepared scope of the study, sampling and the data collection tool. They were also given a short lecture on these aspects of research methodology. On the fifth day, each health NGO presented their research proposal in a plenary session and got feedback from the fellow health NGOs and the partners as the resource persons. This way each health NGO could know what the others are doing and they could learn more about the entire process of research proposal development. On the last day of the workshop, the health NGOs revised their research proposal under the guidance of the partner based on the feedback received in the plenary session. Thus the research proposal along with the data collection tool was finalized. All the proposals were prepared on the same format or guidelines shown in Appendix-4. In all 5 workshops were held in different partner institutions. Out of 57 health NGOs invited, 49 health NGOs attended the workshops. Except one, all others successfully completed the research proposals and the data collection tool. Thus 48 research proposals were prepared. These health NGOs were instructed to translate the interview schedule/questionnaire in the vernacular language and pre-test them in their field area before starting the data collection.

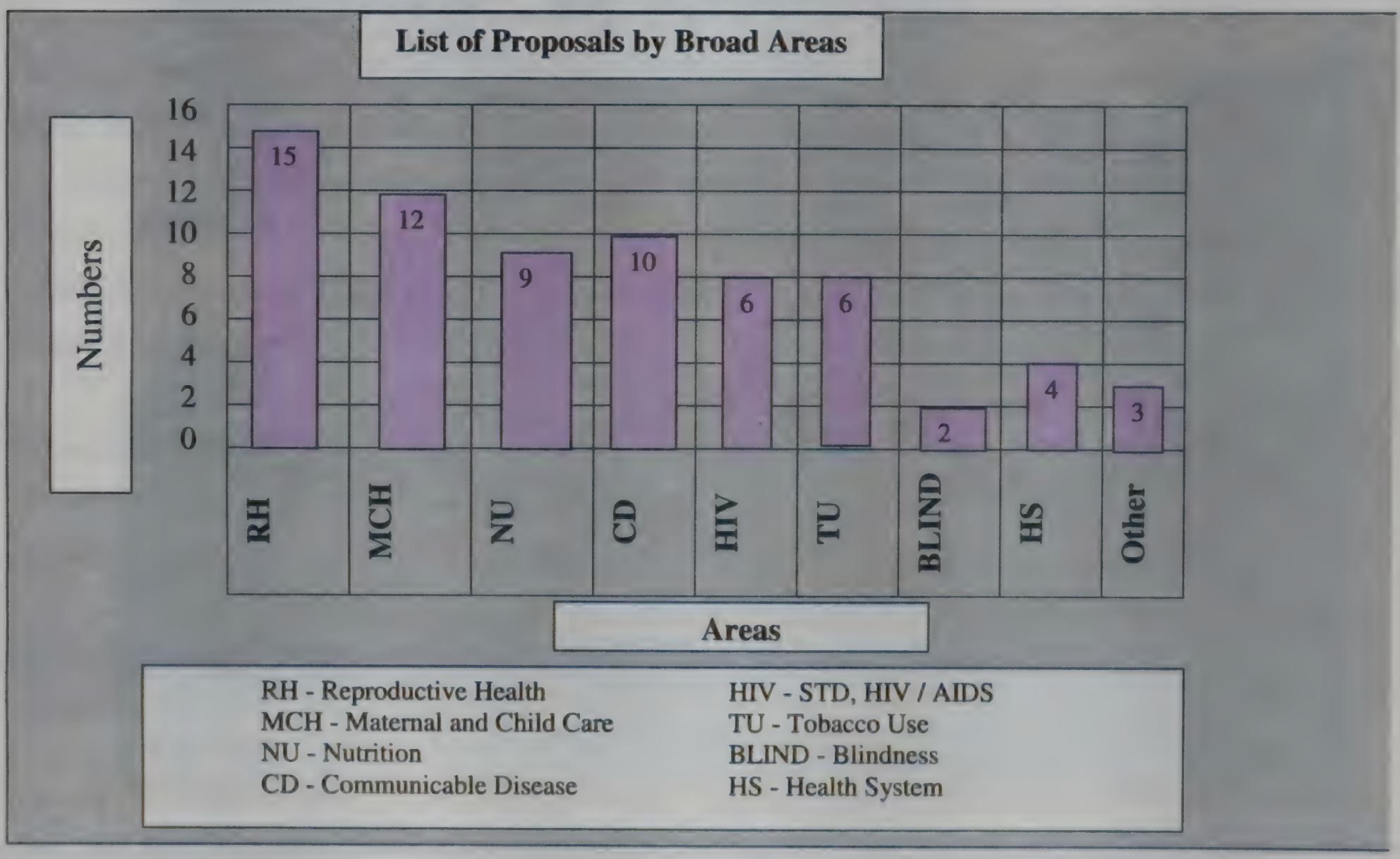
Since some of the backward parts of the country such as northeastern region, Bihar, Uttar Pradesh and Uttranchal were not well represented in the above 48 proposals, another 19 health NGOs from these states were identified and were called for a workshop to prepare research proposals and data collection tool. For this group, both the workshops were combined into a 9-day workshop. This workshop was held in Dehradun and the partners and the health NGOs worked hard to prepare the final proposal and the data collection tool. Therefore in all 67 health NGOs prepared the detailed research proposal and the data collection tool. All these Workshops were held between August and October 2002 and the details are given in Appendix-

5. These health NGOs were asked to complete the data collection within 3 months and to report to the partner institutions.

The proposals prepared by the health NGOs represented varied areas in the field of community health. Diagram-1 gives the details of the community health areas in which these proposals were prepared by the health NGOs.

Diagram - 1

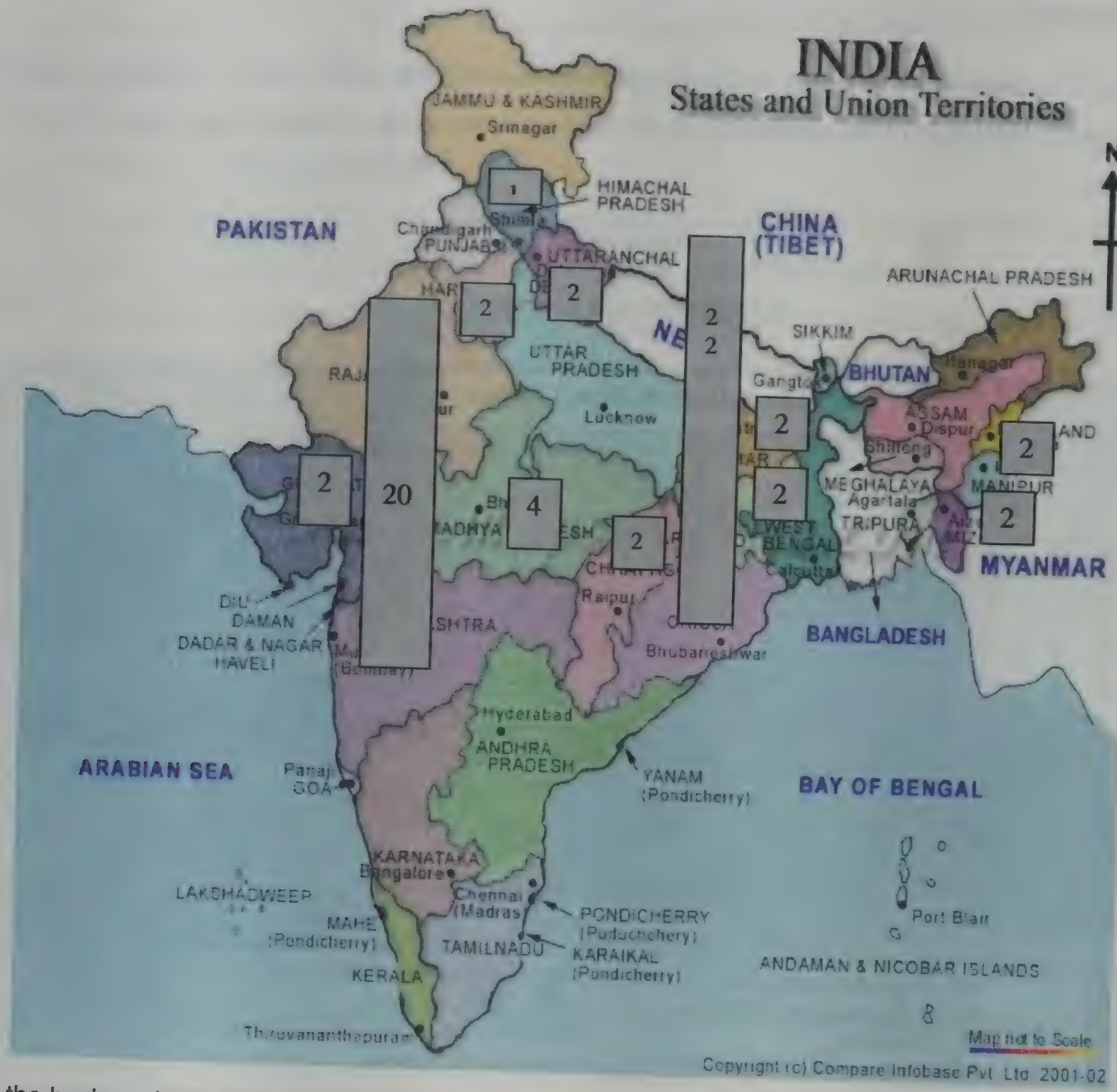
Subject-wise List of proposals



Majority of the proposals were in the broad areas of reproductive and child health area, which included reproductive health, maternal and child health and nutrition. There were 10 proposals dealing with communicable diseases excluding STD and HIV/AIDS. These communicable disease proposals included malaria, tuberculosis, leprosy and so on. Other major areas of the proposals were STD and HIV/AIDS and tobacco use.

The next diagram (Diagram-2) depicts the geographical representation of the research proposals.

Diagram - 2



All the backward parts of the country were represented; especially the backward state of Orissa was well represented. Since the project is located in Maharashtra, there was a good representation from Maharashtra. The southern states were not at all represented. The southern state health NGOs, who had attended the first Workshop in Thiruvananthapuram felt that they had the research capacity and did not proceed further.

Data Collection and Data Processing

After going back, the health NGOs started the task of data collection. First, they translated the data collection tool in vernacular language and pre-tested it with a small number of individuals. They gave the feedback to the partner institution, where they attended the last workshop and corrected the data collection

tool. Then they undertook the task of selecting and training their field level workers for data collection. They also started the sampling process simultaneously as per the proposal. Some of them came across difficulties, which they had sorted out in consultation with the partner institution. Out of the 67 health NGOs, some of them could not collect data and some others collected data but could not proceed further. Some of them had other pressing work; some did not have resources; some had difficulties in convincing their superiors to spend time and resource for data collection; and some had left the health NGOs and none replaced them. Out of 67 health NGOs, 53 of them proceeded to the next phase.

They were invited for a Data Processing and Analysis Workshop in their respective partner institutions. They were instructed to carry with them all the filled-in interview schedules or questionnaires. During the Workshop, they were taught to clean and edit the collected data. They were also taught data entry in either Excel or SPSS for Windows and data processing in SPSS for Windows software. During this Workshop, the health NGOs entered their data in the computer and prepared simple tables for analysis. While 2 partner institutions organized formal Workshops for all of their health NGOs together, one partner institution invited the health NGOs as and when they completed their data collection for data cleaning, editing, entry and processing. The details are given in Appendix-6

Report Writing

Those who had completed the data processing were invited for a 6-day Workshop on Report Writing. The purpose of the Workshop was to prepare a draft research paper along with an action plan, so that the health NGOs could plan field activities based on their research findings. During this period, the health NGO researchers prepared more tables, especially cross-tables and analyzed the data under the guidance of the partners.

Two such workshops were held in Mumbai between June and August 2003 and 36 research papers were prepared by 36 health NGOs. The research report contains the context, objectives, methodology, findings, conclusions and action plan. Since it was an action research, every health NGO had prepared an action plan from the findings of the research study and they would be implementing the action plan in their field areas.

The completed 36 research papers were evaluated by the partners. They were graded as 1, 2 and 3, where grade 1 was the lowest grade research paper and grade 3 was the highest grade research paper. Each paper was evaluated by 2 partners and their grades were added together to arrive at the cumulative grade

for each paper. All the papers were ranked according to their grades. The grade ranged from 2 to 6 wit as the lowest and 6 as the highest. Five research papers were graded 6; 12 research papers were grad 5; 6 research papers were graded 4; 9 research papers were graded 3; and 4 research papers we graded 2.

All the 36 research papers were classified into 5 broad community health areas. They are presented Table-1.

Table 1: Distribution of Research Areas

Sr. No.	Research Area	No. of Projects
1.	Child Health and Nutrition	8
2.	Adolescent Health	7
3.	Women's Health	7
4.	Communicable Diseases	8
5	Non-communicable Diseases	6
	Total	**36**

The table shows clearly that all the important research areas of community health were covered in thi project.

Conclusion

The following table summarizes the whole process that the Project went through.

Table 2 : Project Process

Number of NGOs contacted	2667
Response to First Questionnaire	517
Response to second Questionnaire	208
First workshop attended	157
Number of preliminary proposals received	102
Number of preliminary proposals selected	57
Second workshop attended	49
Number of final proposals prepared	48
Additional proposals of backward region	19
Total Research proposals	67
Number of NGOs completed Data Collection and Data Processing	53
Number of Health NGOs completed the Research Report	36

The table clearly shows the vivid process undergone in the Project to develop research capacity in the health NGOs. The net was widely spread with 2667 health NGOs ending up with 36 health NGOs completing the whole process of research capacity development. The project proposal envisaged research capacity development in only 15 health NGOs. Those who had dropped out in the middle also had gained research capacity to lesser extent. The task ahead is to prepare the action plan out of the research findings and to implement them in the field area. The 36 health NGOs are already planning the healthcare programme based on the research findings. A few have already started the implementation.

Programme of Research Capacity Development Workshop

Day 1	9:00 - 9:30 a.m.	Registration
	9:30 - 10:30 a.m.	Inauguration
	11:00 - 1:00 p.m.	NGO Presentation
	2:00 - 3:30 p.m.	NGO Presentation
	3:45 - 5:00 p.m.	Research for Health Development
	5:00 - 7:00 p.m.	Use of Research in Health Programmes - Sharing Experiences
Day 2	9:00 - 11:00 a.m.	Profile of a typical Research project - Theoretical Brief
	11:15 - 1:15 p.m.	Profile of a typical Research project - Quantitative study
	2:00 - 3:30 p.m.	Qualitative Study
	3:45 - 7:00 p.m.	Problem Formulation and Setting of objectives - research Objectives - group exercise
Day 3	9:00 - 11:30 a.m.	Problem Formulation and Research Objectives - Plenary Session
	11:45 - 1:00 p.m.	Plenary Session - continued
	2:00 - 3:30 p.m.	Identifying individual research areas -group work
	3:45 - 7:00 p.m.	Individual Research Problem Identification and objectives : working with resource persons
Day 4	9:00 - 11:00 a.m.	Presenting individual research plan in small groups
	11:15 - 1:00 p.m.	Individual tutorials with resource persons
	2:00 - 3:30 p.m.	Finalizing research topic, objectives and variables - small group
	3:45 - 5:00 p.m.	Finalizing research topic, objectives and variables - Plenary session
	5:00 - 7:00 p.m.	Guidelines for proposal writing
	7:00 - 8:00 p.m.	Valedictory Function
	8:00 - 10:00 p.m.	Valedictory Dinner

Appendix 2

Venue of Research Capacity Development Workshops

Sl. No	Partners	Venue	Date
1	SCTIMST	Thiruvananthapuram	3 - 6 April 2002
2	BAIF	Pune	8 - 12 April 2002
3	CINI	Kolkata	15 - 19 April 2002
4	BAIF	Pune	22 - 26 April 2002
5	IHMP	Pachod	29 April - 3 May 2002
6	CINI	Kolkata	6 - 10 May 2002
7	IHMP	Pune	20 - 24 May 2002
8	TISS	Mumbai	3 - 6 June 2002

Programme Schedule for Workshop on Enhancing Research Capacity of Health NGOs

Day 1		Day 2	
Timing	**Particulars**	**Timing**	**Particulars**
9:00 - 9:30 a.m	Registration	9:00 -10:00 a.m.	Introduction to tools of data collection
9:30 - 10:00 a.m	Welcome Address		
10:00 - 1:00 p.m	Correcting preliminary proposals - individual counseling	10:00 - 1:00 p.m.	Preparing data collection tool : Individual counseling
2:00 - 3:30 p.m.	Correcting preliminary proposals - individual counseling	2:00 - 3:30 p.m.	Testing data collection tool : mock interview
4:00 - 5.30 p.m.	Steps of a research proposal	4:00 - 5.30 p.m.	Finalizing data collection tool: individual counseling
Day 3		**Day 4**	
9:00 - 10:00 a.m	Introduction to sampling design	9:00 -10:00 a.m.	Introduction to data analysis
11:00 - 1:00 p.m	Preparing sampling design: individual counseling	11:00 - 1:00 p.m.	Preparing dummy tables: individual counseling
2:00 - 3:30 p.m.	Plenary session on sampling design	2:00 - 3:30 p.m.	Preparingthe full proposal: individual counseling
4:00 - 5.30 p.m.	Plenary session on sampling design	4:00 - 5.30 p.m.	Preparingthe full proposal: individual counseling
Day 5		**Day 6**	
9:00 - 10:30 a.m.	Plenary session: Presentation of the full proposal	9:00 -10:30 a.m.	Finalization of the research proposal for data collection: individual counseling
11:00 - 1:00 p.m.	Plenary session: Presentation of the full proposal	11:00 - 12:30 p.m.	Finalization of the research proposal for data collection: individual counseling
2:00 - 3:30 p.m.	Plenary session: Presentation of the full proposal	12:30 - 1:00 p.m.	Valedictory function
4:00 - 5.30 p.m.	Plenary session: Presentation of the full proposal		

Proposal Guidelines

1. Face Sheet
2. Name and address of the Organization
   - Name of researcher
3. Research Topic
4. Background
5. Objectives
6. Items and source of information
7. Scope of Study
   - Location
   - Population
   - Target Population
8. Method of data collection
9. Sample design
10. Data Analysis Plan
11. Research project Timeframe
    - Translation and Pre-testing
    - Training of investigators
    - Data Collection
    - Data processing and analysis
    - Report writing
12. Annexure
    - Interview Schedule / Questionnaire

Appendix 5

Venue of Proposal Writing Workshops

Sl. No	Partners	Venue	Date
1	BAIF	Pune	5 - 10 Aug 2002
2	CINI	Kolkata	19 - 24 Aug 2002
3	IHMP	Pachod	2 - 7 Sept. 2002
4	CINI	Kolkata	23 - 28 Sep. 2002
5	IHMP	Dehradun	11 - 19 Oct. 2002

Appendix 6

Venue of Data Analysis Workshops

Sl. No	Partners	Venue	Date
1	BAIF	Pune	January 2003
2	IHMP	Pachod	27th - 30th January 2003
3	IHMP	Pachod	17th - 22nd March 2003
4	CINI	Kolkata	January to June 2003

Section I : Lessons Learnt

Dr. A. Dyalchand

LESSONS LEARNT

Dr. A. Dyalchand

Introduction

In January 2001, a project was initiated for "Strengthening of Health Research Capacity in Non-Government Organisations in India". The Department of Health Services Studies, Tata Institute of Social Sciences, Mumbai, implemented this project in partnership with

- Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
- BAIF Development Research Foundation, Pune,
- Child In Need Institute, Kolkata
- Institute of Health Management, Pachod, Aurangabad.

The specific objectives of the Project were as follows:

1. To develop capacity in NGOs to undertake epidemiological and social science research and make use of the study findings for planning health care programs.
2. To provide technical assistance to the NGOs to develop research as part of the health care program and to translate research into action (action research).
3. To develop skills within the NGOs to monitor and evaluate their health care programs.

The details of the implementation of the project is explained in detail in the paper titled "Overview of the Project" by C.A.K. Yesudian.

Having gone through a nearly three year period of implementation, the partners felt that a very useful purpose would be served if they could reflect back on what and how they had been able to implement the project to develop the research capacity of health NGOs, whose prior knowledge and skills in research was minimal.

Objectives and methodology of evaluation

The purpose of this evaluation is to document the learning experiences of the health NGOs and the reflections

of the partners regarding the organization and management of the Project. The specific objectives of the evaluation are as follows:

1. To ascertain from the health NGOs their perspective on specific aspects of the research skills acquired by them, the experiences with the training, content, methodology, organization and management of the Project and suggestions for improving any such future projects.
2. To discern the partners perception of the strengths and weaknesses of the organization and management of the Project as well as the content of the partnership.
3. In the light of the findings of the above two objectives, to derive meaningful lessons for designing and implementing similar projects in future.

To achieve these objectives relevant data were tapped from the following sources

a. Health NGOs' Responses to Mail Questionnaire:

To ascertain the Health NGOs' views on 17 research oriented skills imparted to them, a suitably designed questionnaire was mailed to them. These 17 skills of the capacity building process for action research, were presented as below under six broad areas.

A. Problem Identification and Definition	
1	Identify a research problem
2	Develop a research objectives
3	Develop items of information and source of information
4	List information to be collected for the study
5	List the sources for each item of information
B. Research Design	
6	Develop a research design: scope of study and sampling design
7	Design an interview schedule or a questionnaire
C. Data Collection	
8	Train investigators for collecting data
9	Translate interview schedule questionnaire in local language and pre-testing
10	Collect data from the field by interviewing respondents
D. Data Processing	
11	Clean and edit the data collected from the field
12	Manage / process field data
13	Analysing the data
E. Report Writing	
14	Interpret the data and draw inferences
15	Write research report / paper
F. Towards Effective Implementation	
16	Using research findings for project implementation
17	Implementing action plan

Health NGOs assessed each of the 17 skills against the following five indicators:

1. Level of participation in training
2. Relevance of the skills acquired for undertaking action research.
3. How understandable the training contents were for each skill
4. The adequacy of time allotted to each skill
5. The level of confidence of the health NGO to use the skills in future

In addition to the above, the health NGOs were requested to give their experiences related to the organization of the Project and most importantly the nature of research capacity they had imbibed and the utility of the research skills in their health development efforts, as well as the partners, who were the resource persons.

The mailed questionnaire was sent to 66 health NGOs who had completed at least two of the workshops and prepared an approved proposal for the study. Of these 66, as many as 36 health NGOs had completed the capacity building process by attending all four workshops and submitted draft research reports and 30 health NGOs had attended two or three workshops and for some reason could not complete their training. In this study, 26 health NGOs who had completed the training (72 % response rate) and 20 health NGOs who attended the training partially (66 % response rate) had responded.

b. Partners' Reflections :

At the consultative meeting of six of the eight partners held in Kochi on September 13, 2003, a brain storming session was held. It was facilitated by one of the partners. The partners reflected on the the Project from two angles: (a) the partnership and (b) the health NGOs.

c. Online Independent Evaluation of the Partnership :

A mid-term evaluation of the partnership was initiated by WHO – RPC/EIP in Geneva, which was providing technical support to the Project. An online questionnaire was filled by all eight resource persons associated with the five partner organizations. This evaluation was conducted by Centre for the Advancement of Collaborative Strategies in Health, U. S. A. (www.PartnershipTool.net)

Major findings

Major findings have been presented in three parts:

(i) health NGOs perspective of research skills acquired by them,

(ii) assessment of project organization and management and

(iii) partnership for the Project.

Health NGOs Research Skills

A summary of the health NGOs' perspective on the 17 research skills imparted to them and their assessment of these skills based on the five indicators are presented in Appendices 1 and 2. Table in Appendix-1 presents the perspective of the health NGOs who participated in all the 4 workshops. Table in Appendix-2 pertains to those of the health NGOs who attended only 2 or 3 of the 4 workshops. The overall findings that emerged are as follows:

A. For the five skills under problem formulation, most of the health NGOs, irrespective of whether or not they had completed all workshops, had participated in the learning of problem formulation skills. All of those who had completed the workshops and most of those who had attended some of the workshops, found the learning of problem formulation relevant for them. In terms of understanding of the content, most of those who had completed the workshops as well as those who had completed only some of the workshops found it easy to grasp the research skill of problem formulation. Similarly, a large majority of both the groups said that time allotted for learning problem formulation skills was adequate. Finally, regarding the confidence gained in formulating research problems, a large majority of both the groups were confident of independently formulating research problem.

B. For the two skills of research design and preparing interview schedule, it would be useful to keep in mind that these skills are quite technical in nature. Therefore, it is not surprising that compared to the problem formulation skill, there was a marginal drop in the percentage of health NGOs on the five indicators of participation, relevance, content, time and confidence. However, all these five indicators clearly showed that a large majority of the health NGOs had positively gained these research skills.

C. Coming to the three data collection skills of investigator training, translation of data collection tool and field data collection, most of them from both the groups had actively participated; found these very relevant; easily understood the content; found the time allotted for data collection adequate; and finally had high degree of confidence to undertake this task independently.

D. Data Processing skills included data cleaning and editing, computerization of the data and preliminary analysis. Since many health NGOs were not accustomed to computers, there was a perceptible decrease in the positive rating on the five indicators. This is best reflected in their assessment of the confidence they had in independently executing this set of research skills. Thus less than half of the health NGOs who had completed all the workshops and one-third of the health NGOs who had completed some of the workshops were confident of using this set of skills independently.

E. Report writing skills of data interpretation and writing descriptive report was offered only in the last workshop. Hence the result pertains to only those who had completed all the workshops. From the table, it is clear that a sizable proportion (23.1%) of the health NGOs had depended on the resource persons for the interpretation of data. Therefore, just a simple majority of 53.8 percent were confident of being able to undertake this task on their own. On the other hand, while most of them (92.3%) participated in writing descriptive draft report, a lower proportion of health NGOs (69.2%) were confident of undertaking this task.

F. As regards the last area, Towards Effective Implementation, no attempt has been made to analyse their responses as the health NGOs, at this point of time, are involved in implementing their programmes and it is a little too early to get their reactions on this phase of the project.

Overall comparison of the responses with respect to five areas clearly brings out the fact that the health NGOs learnt easily and were quite confident of using the skills of problem formulation, data collection and report writing. They had some difficulties with respect to the two technical areas of research skills, viz. research design and data processing. But it must be said to their credit that more than two-thirds of them were positive that they could undertake survey designed research studies on their own with minimal guidance.

In response to a general question as to the benefits that they had derived by attending the workshops, the following responses constitute the typical sampling of opinions expressed by the health NGOs :

1. Taught how to be more focused when selecting a subject for study, and importance of clearly identifying the problem. Objectives must be clear cut. Also, fewer the objectives more accurate and well planned a project would be.
2. Learned all skills on conducting a research study except data analysis and processing using SPSS software.

3. It was benefiting for the fact that it was a collaborative effort.
4. It was very helpful to self and organisation that sometimes we don't know whatever action we have taken, we don't know the result. In this process we are able to get the knowledge again.
5. This has surely built my strength in undertaking research work and implement the recommended actions after the research work. My organisation and I have used these techniques of research and planning in implementing RCH programme in six villages.
6. The whole exercise has helped me to see how the field work can be improved based on the findings of the research (objective) rather than on what one feels (one's own perspective)
7. Exchange of ideas, practices and dissemination of thoughts in this network meet was beyond expectation. The personality and co-operation of resource persons encouraged me to go ahead in the whole process.
8. I learnt how to identify a research problem, prepare the items of information according to the objective. Learnt some of the software packages.

Project Organization and Management

In this section, information pertaining to the following two aspects are presented: (i) organization and process of capacity building and (ii) role of the partners as resource persons.

Organization and Process of Capacity Building Exercise :

Capacity building in this project is defined as demystifying applied research as a tool for effective project implementation; developing the ability in NGOs by improving their knowledge, attitudes and skills for research and its use in project planning, monitoring and evaluation; imparting various skills to conduct action research and write reports; and increasing the confidence of health NGOs in dealing with community, peers and funding agencies. Given this definition, the partners had observed the following:

The manner in which the demystification of research methodology was achieved was a major success. This had been confirmed by the health NGOs on how they were in a position to utilize their learning not only in undertaking research in future but also in planning and implementing their community health projects.

The project achievement was more than the planned target – 36 health NGOs were trained in place of the 15 originally planned. The partners suspected that this quantitative achievement could have affected to some extent the desired quality of capacity building because as against the planned 2 health NGOs to be

guided by each resource person, the ratio had increased to 4.5 health NGOs per resource person.

A major strength of the Project was a high degree of self-selection of health NGOs based on commitment rather than existing expertise. This had resulted in enrolling health NGOs with widely varying capacities including language, knowledge, computer skills and infrastructure. This could have resulted in differential input from partners including partners taking over some of the research skills rather than imparting these to the concerned health NGOs. Despite this limitation, a good majority of the health NGOs, as already mentioned in the previous section, reported confidence in undertaking action research independently.

The geographic distribution of health NGOs allowed research to be conducted in several tribal and remote parts of the country. The health NGOs had selected common themes like child health, adolescent health, women's health, communicable diseases and non-communicable diseases. It is now evident that with more foresight, the project could have organized multi-centric studies, that would have substantially contributed not only to research capacity building but also to building of substantive knowledge on these very themes.

Considering the long duration of the Project, coupled with the diversity of the health NGOs, conflicting demands of the resource persons as well as the intricate steps in research, it did not seem feasible in the beginning to develop a detailed step-by-step plan of implementation. Hence while an overall plan of action was in place at the outset, the detailed planning evolved only as the Project progressed.

Regarding the process of group work among the health NGOs, most of them felt that it was informative and enabled sharing of knowledge, albeit it was very limited. Group work provided an opportunity to observe how other health NGOs developed their proposals at various stages and how they reacted during group discussions. Group work resulted in learning about the topics and research methodology of other health NGOs. Since the groups were large, group work resulted in some waste of time for health NGOs. Smaller groups should be there for each workshop, so that proper attention can be paid at the individual level. They felt that group work could have been made more interactive and participatory.

At the individual level, without any exception, all the health NGOs felt that the project was very useful at the individual level. They learnt several skills from the four workshops. The sequential arrangement of the workshops was excellent. Even the health NGOs who could not complete the entire training and research workshops felt that they had acquired a substantial number of research and related skills.

All the workshops were well organized as a result of which the capacity building objective was achieved. Overall, sufficient time was provided to build capacity of the health NGOs in action research. Some health NGOs felt that the workshops were well spaced out, but a considerable number felt that the interval between successive workshops was too long and resulted in a degree of de-motivation. The logistic arrangement for the workshops was excellent but time got wasted, as there were a large number of health NGOs and an inadequate number of resource persons for each workshop.

Processing and analysis of data, use of computers, report writing and action plan received much less time than they deserved. Health NGOs felt that data analysis should have been done with a software that is more readily available, and cheaper than SPSS.

A well-designed training manual was produced on time and was very useful for the Project. Most health NGOs felt that the manual was easy to follow even for the most inexperienced health NGOs. A few were encouraged to consult appropriate documents and books in order to develop their research themes. Yet some health NGOs felt that they should have been guided to do literature review on their topics before finalizing their research proposals.

Role of Partners as Resource Persons :

The findings on this dimension have been derived from two sources. These are the experiences of the health NGOs from their interactions with the resource persons and reported by them in the questionnaire, and the brainstorming session conducted by the resource persons themselves.

Only six of the 47 health NGOs had any comments to offer on the role of the resource persons. They felt that there should have been better planning and preparation for this Project, and resource persons should have had more interactions with health NGOs at the individual level. A resource person allotted to a health NGO so that he/she he could guide the same individual NGO from the beginning to the end of the Project and devote more time to teach data processing and analytical skills. Several health NGOs felt that some of the resource persons lacked substantive knowledge about the subject /topic for which they were guiding the health NGOs or were too theoretical. Several health NGOs felt that there should have been more field visits for hands-on skills development. Most health NGOs felt that they could not learn data processing and analysis skills, as the inputs for this module were not sufficient.

The strength of the partnership was the diversity of knowledge and experience of the resource persons.

However, this strength was not fully exploited to the benefit of the health NGOs. This was partly due to the self-selection of topics by the health NGOs, which in turn resulted in permitting health NGOs to select topics of relevance to their field area.

Though the goal of the partnership was clearly defined and explicit, yet the role of the same partner as resource person was not fully operationalized. Despite this, partners were supportive to each other and compensated as and when and where needed. Though all the resource persons could not make themselves available for all the workshops due to their prior institutional commitments, yet, because of the supportive role played by other partners, the Project was completed on time. Due to the varied backgrounds of the partners, it was not unexpected that there were occasions when partners were not able to accept constructive comments. However, due to joint responsibility coupled with collective functioning and decision-making process, the partners could arrive at definitive consensus to ensure that the Project moved smoothly towards the stated goals. Thus it provided space for the partners to discus, disagree and yet take decisions and never allow differences to disperse the partnership. This was in no small measure the result of excellent leadership and coordination.

Some resource persons lacked field knowledge/ practical information. Their lectures were theoretical and not in conformity with ground realities and practical difficulties. Project preparation strategies could have been deduced properly and field exercises should have been undertaken

Evaluation of Partnership:

Partnership was defined as a coordinated collaboration among several organizations leading to collective action and sharing and complimenting each other's knowledge and skills to attain a common goal. The partnership was unique in the type of organizations that were brought together – three NGOs and two academic institutions.

The results of the earlier mentioned online survey were presented by the external evaluators on a five-point scale with the following categories: danger zone: 1 to 2.9; work zone: 3.0 to 3.9; headway zone: 4.0 to 4.5; and target zone: 4.6 to 5.0.

According to the online survey results :

the leadership effectiveness measured on 10 items was in the work zone with an average score of 3.8 ranging from 3.6 to 4.1,

Efficiency of partnership measured on three items was in the work zone with an average score of 3.8 and ranging from 3.5 to 4.5,

Administration and management of partnership measured on 9 items was in the work zone with an average score of 3.6 ranging from 3.3 to 4.3,

Sufficiency of non-financial resources was assessed through 6 items placing the partnership on the headway zone with an average score of 4.0 and ranging from 3.6 to 4.3,

Sufficiency of financial resources assessed through 3 items was in the headway zone with an average score of 4.1 and ranging from 4.0 to 4.1.

Collectively the *partnership synergy* was measured on 9 items and placed in the work zone with an average score of 3.8 with a range from 3.3 to 4.4.

The partnership was also measured on decision making and satisfaction levels.

Decision Making: A large majority of 75 percent of the partners were comfortable with decision making and extended support to decisions all of the time or most of the time. Three out of every five felt that they were not feeling left out of decision making process.

Levels of Satisfaction: This was assessed on five components and the results are as follows. A large majority of 75 percent were completely or mostly satisfied with regards to work, influence in partnership and role in partnership. This percentage rose to 87.5 percent with respect to plan of action and implementation of plan.

Conclusions

Project

1. The project resulted in substantial and measurable change in the capacity of the health NGOs to undertake applied research.
2. The project was successful because the project objectives were specific and measurable and in consonance with the overall goal, even though they evolved over a period of time as the project proceeded.
3. After undergoing capacity building in research all the health NGOs felt that applied research can help them in implementing their field programs more effectively.
4. Health NGOs felt more confident in using skills, which were simple and non-technical in nature such as problem identification and definition, data collection and using research findings for effective project implementation.

5. Health NGOs were less confident in using certain research skills such as developing a research design, and data processing and analysis. More time should have been allotted to the more complex skills that required conceptual understanding and analytical competencies.
6. The geographic distribution of the participating NGOs was such that the research studies could be undertaken in several tribal and remote parts of the country.
7. NGOs participated on the basis of self-selection and interest rather than selection based on merit. The self selection resulted in inclusion of a few NGOs with pre-existing skills but mostly of NGOs that were doing research for the first time. The results of this assessment therefore indicate the increase in the capacities of NGOs having the least skills in undertaking applied research.
8. The training content of some of the modules could have been done in greater depth.
9. Whenever health NGOs had faced difficulties in handling particularly technical skills, resource persons tended to take the initiative rather than strengthen the capacity of health NGOs.
10. Whereas the resource persons could provide sufficient inputs for research design, methodology, and research skills like developing instruments, and plan of analysis, it would have been more beneficial to the Project if they had adequate knowledge in more than one substantive area.

Partnership

11. The project had very good leadership and stewardship because of which the partnership was sustained for almost three years.
12. Decision-making for the project was participatory and partners were quite comfortable with the decisions and supported the decisions.
13. Administration and management of partnership in terms of organizing partnership activities, coordinating communication among partners, minimizing barriers of partnership, performing secretarial duties and similar other elements of administration and management was found to be good.
14. There was a sense of ownership resulting in high degree of satisfaction with ability to influence partners, active role in partnership, plan of action and implementation.

Lessons learnt

Things to do the same way

1. There is a huge potential for capacity building in applied research for NGO health workers. The response by the NGOs to this project evaluation confirmed this potential.
2. Capacity building through a process of 'hand holding' by organizing a series of modular training workshops was found to be an effective way of providing research skills. Skills development is more

effective if the training is given as the health NGOs continue to conduct their research. As opposed to this method, a single induction training may not have been as effective.

3. Conceptual and analytical skills are difficult to impart, especially, to health NGOs that have had no prior exposure to applied research. More time and inputs are required for developing these skills.
4. Interest and commitment are more important as selection criteria for health NGOs than pre-existing ability and research competencies. NGOs who fulfill these criteria get selected automatically through a process of self-selection.
5. Didactic training combined with experiential field learning can result in an increase in the capacity of NGOs that have the least skills for undertaking applied research.
6. Stewardship is as important as leadership, for sustaining a long term partnership extending over a period of several years.

Things that should be done differently

1. The expectations from the partners were unrealistic. Competing demands on the time of the partners needs to be kept in mind while planning a project of three years duration.
2. The willingness of partners to commit their time is as important as the expertise they are able to offer.
3. In order to sustain a partnership for such a long period there is an imperative need of ownership among the partners. Frequent change of health NGOs and topics from one resource person to another needs to be avoided.
4. Space needs to be created for health NGOs to grow at their pace. The outcome of the research study must not become the goal in place of capacity building of the health NGOs.
5. Major changes in the scope of the project over time can result in problems in sustaining a partnership and should be avoided.
6. There was need for debriefing after each stage of the project to make mid course corrections. The learning from this project could have been far greater if there had been regular debriefing among the partners.
7. Resource persons need to do substantial preparation on the subject of research selected by the health NGOs allotted to them.
8. There should be a pair of resource persons for each trainee participant so that the two can coordinate and support each other, thereby overcoming each other's weakness.

9. Health NGOs must be encouraged to review the literature on their research topics.
10. There is a need to ensure that quality is not sacrificed for the sake of quantity.
11. Common interest in topics should be identified when the project is initiated and several multi-centric research studies should be planned and conducted in various geographic settings. The research could have captured the variation due to different social settings and it would have been easier for the resource persons to provide inputs to a group of health NGOs with the same topic.

Health NGO Perspective of Research Skills Imparted and Gained (Responses of those who completed all workshops)

	Participation (in %)		Relevance (in %)	Content (in %)		Time (in %)		Confidence (in %)	
	You were helped/ made to do this	A resource person did it for you	Relevant	Easy to Understand	Partially Understood	Too Much Time Allotted	Adequate Time Allotted	Very Confident	Somewhat Confident
PROBLEM FORMULATION									
Identify a research problem	92.3	7.7	100.0	96.2	3.8	15.4	80.8	80.8	15.4
Develop a research objectives	88.5	11.5	100.0	100.0	.0	7.7	92.3	73.1	23.1
Develop items of information and source of information	88.5	11.5	100.0	96.2	3.8	15.4	84.6	80.8	19.2
List information to be collected for the study	92.3	7.7	100.0	96.2	3.8	11.5	84.6	80.0	20.0
List the sources of information for each item of information	88.5	11.5	100.0	96.2	3.8	15.4	84.6	80.8	19.2
RESEARCH DESIGN									
Develop a research design: scope of study and sampling design	65.4	34.6	96.2	76.9	23.1	11.5	84.6	73.1	26.9
Design an interview schedule or a questionnaire	80.8	19.2	100.0	100.0	.0	7.7	88.5	73.1	26.9
DATA COLLECTION									
Train investigators for collecting data	92.3	7.7	92.3	92.3	7.7	7.7	80.8	84.6	15.4
Translate interview schedule/questionnaire in local language and pretesting	84.0	12.0	92.0	96.0	4.0	7.7	88.5	88.5	11.5
Collect data from the field by interviewing respondents	92.3	7.7	100.0	100.0	.0	19.2	73.1	88.5	11.5
DATA PROCESSING									
Clean and edit the data collected from the field	61.5	38.5	96.2	76.9	23.1	8.0	80.0	42.3	53.8
Manage and process field data	57.7	42.3	92.3	61.5	38.5	7.7	69.2	46.2	46.2
Analysing the data	65.4	30.8	96.2	65.4	34.6	8.0	68.0	50.0	34.6
INTERPRETATION REPORT WRITING									
Interpret the data and draw inferences	76.9	23.1	92.3	65.4	34.6	7.7	76.9	53.8	42.3
Writing a research report or paper	92.3	7.7	100.0	88.5	11.5	7.7	69.2	69.2	30.8

Health NGO Perspective of Research Skills Imparted and Gained (Responses of those who dropped out of the programme)

	Participation (in %)		Relev ance (in %)	Content (in %)		Time (in %)		Confidence (in %)	
	You were helped/ made to do this	A resource person did it for you	Relevant	Easy to Understand	Partially Understood	Too Much Time Allotted	Adequate Time Allotted	Very Confi-dent	Somewhat Confident
PROBLEM FORMULATION									
Identify a research problem	89.5	5.3	100.0	94.7	5.3	16.7	77.8	73.7	21.1
Develop a research objectives	89.5	5.3	95.0	94.7	5.3	16.7	77.8	84.2	10.5
Develop items of information and source of information	89.5	5.3	95.0	94.7	5.3	16.7	83.3	73.7	21.1
List information to be collected for the study	100.0	.0	100.0	94.7	5.3	15.8	84.2	84.2	10.5
List the sources of information for each item of information	94.7	5.3	95.0	94.7	5.3	15.8	84.2	73.7	21.1
RESEARCH DESIGN									
Develop a research design: scope of study and sampling design	94.4	5.6	95.0	73.7	21.1	15.8	68.4	60.0	25.0
Design an interview schedule or a questionnaire	94.7	.0	95.0	94.7	5.3	15.8	78.9	70.0	20.0
DATA COLLECTION									
Train investigators for collecting data	88.9	5.6	95.0	94.7	.0	11.1	83.3	75.0	15.0
Translate interview schedule/questionnaire in local language and pretesting	84.2	5.3	95.0	94.7	.0	11.8	82.4	85.0	10.0
Collect data from the field by interviewing respondents	85.0	5.0	100.0	95.0	5.0	.0	94.7	85.0	10.0
DATA PROCESSING									
Clean and edit the data collected from the field	68.4	10.5	94.4	66.7	22.2	.0	81.3	33.3	44.4
Manage and process field data	72.2	11.1	94.1	64.7	17.6	6.3	62.5	33.3	44.4
Analysing the data	75.0	6.3	93.8	62.5	18.8	7.1	57.1	29.4	41.2

Section II - Abstracts of Research Projects

CHILD HEALTH AND RELATED ISSUES

Aspect A : Infant deaths

1. Women who experienced still-Births
   Rachel Kumar, The Duncan Hospital.

2. Factors associated with infant deaths
   Souravamaya Das, YCDA

Aspect B : Malnutrition Among Children

3. Factors associated with Malnutrition among Children aged 12-24 months
   T K Mohanta, CREFDA

4. Factors associated with Malnutrition among Children aged 12-18 months
   Pramod Perua, SEWA

5. Breast-Feeding and Weaning Practices in Tribal Villages
   Bimal Kumar Panda, CARD

6. Child Health practices of Tribal Mothers having Children upto 2 years
   Kailash Chandra Palo, PRAGATI

Aspect C : Role of Public Agencies : Members Perception of Their Role in Health programmes

7. Level Of Awareness About Key Health Programs Amongst Panchayat Representatives
   Ameen Charles. Dayanand Dhurware, CDC

8. Knowledge and Interest level of Members of Women SHGs about Universal Immunization Programme
   Bhikari Charana Behera, PEACE

OVERVIEW

HEALTH ISSUES RELATING TO CHILDREN

Considering the various dimensions of children's health and wellbeing, the three primary areas in which interest has been focussed in recent times are:

1. Infant deaths
2. Child health and nutrition, and
3. Role and responsibilities of civic representatives.

In this document we shall look at each of these from a brief global perspective and present findings of seminal studies that have been done in different communities in India.

A - INFANT DEATHS

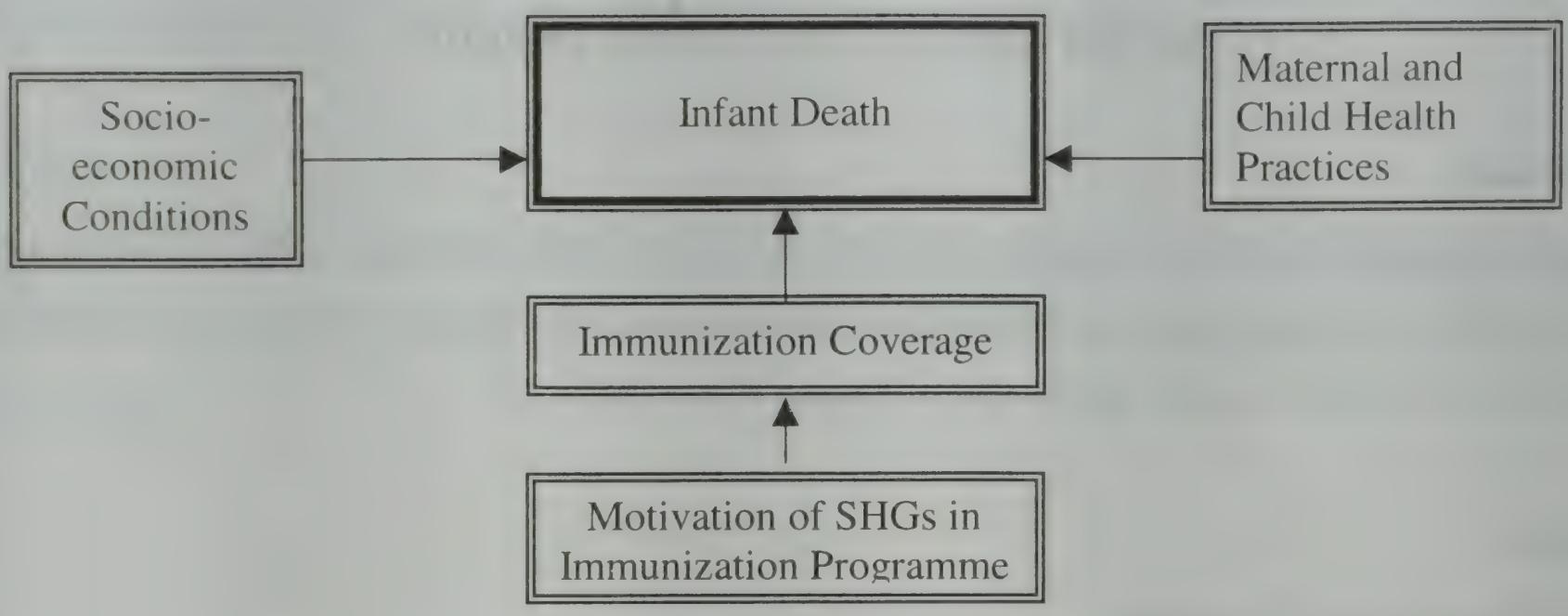
Introduction :

Infant mortality rate in India has declined from 86 in 1984-88 to 68 in 1994-98. This was possible due to active implementation of the immunization programme in the country. However the achievement is not uniform in all parts of the country. Infant mortality in backward rural and tribal areas is still high. This is mainly due to lower socio-economic conditions such as low income, poor nutrition, low education and poor access to health services. Apart from the socio-economic conditions, infant mortality is affected due to early marriage, obstetric history, birth spacing, delivery practices, low birth weight, birth order, breast-feeding, weaning practices and finally immunization coverage.

According to National Family Health Survey II (NFHS II), the immunization coverage in rural areas is almost half of urban areas and the utilization of immunization services by children of illiterate mothers was one-third that of children of high school educated mothers. Therefore it is clear that though we are making progress in better coverage of immunization services and reducing infant mortality, still there are areas in the country where immunization coverage is poor and infant mortality rate is high.

The basic fact that remains is that there are a large number of deaths among infants and in some pockets the stillbirths are a serious matter of concern. It is for the purpose of getting first hand information of the manifestations of infant mortality that two studies have been taken up in remote parts of the country. The present project, therefore, explores the extent and incidence of infant mortality in the three stages from still-births through neonatal mortality to neonatal infant deaths.

Conceptual Framework



The objectives of the two studies that encompass these three stages are:

(i) ascertaining the proportion of stillbirths among hospital deliveries, and

(ii) determining factors associated with still-births, neonatal deaths and post natal deaths.

Abstracts of the two studies that have been undertaken in this context are presented below.

Women who Experienced Still-Births

by

Rachel Kumar, The Duncan Hospital

Background :

Stillbirth is a frequent occurrence in India. In Bihar this is 10.9 per 1000 (Mahabir, 1999). At Duncan Hospital of Raxaul in Bihar, where almost one-third of the patients come from Bihar and Nepal, the stillbirth rate is eight to ten times higher than the above figure (84 per 1000, 2002-03).

Objectives :

The objectives of the study include

I. ascertaining the proportion of stillbirths among hospital deliveries

II. determining factors associated with still-births, and

III. developing a community based strategy to prevent still-births

Methodology :

All pregnant women who came to the Duncan Hospital for delivery were taken as the study population. Out of 1000 deliveries in a select period of four months, 90 deliveries ended in still-birth. These 90 still-births (as case) along with another 90 live births (as control) were selected as samples for this study. The control sample of 90 was matched with the 90 still-birth cases on age, education and economic status.

Major Findings :

There are clear differences between cases relating to still-births and those relating to live-births as the statistical summary presented below reveals.

Parameter	Still births	Live births
Women who did not attend ANC	51%	25%
Not taking Iron and Folic acid tablets	60%	31%
Not received pitocin injections	35%	15%
Prolonged labour	34%	14%
Having acute intra uterine infections	41%	11%
Chronic pelvic inflammatory disease	50%	21%
History of respiratory tract infection	44%	11%
Placental infarcts	34%	8%
Ruptured uterus	10-cases	—

Conclusion :

Infections during pregnancy, poor antenatal care and placental anomalies seem to be the main causes of stillbirths in this area.

Action Plan :

To prevent stillbirth, further training is needed for the staff of health projects, local private medical practitioners, students and nurses of the hospital to impart proper counseling and appropriate antenatal check up to pregnant women.

Factors Associated With Infant Deaths

by

Souravamaya Das, Youth Council for Development Alternatives (YCDA)

Background :

The extremely high infant mortality rate of 127 per 100 in its project area, has prompted YCDA to undertake this project to track the factors responsible for the phenomenon.

Objectives :

The specific objectives of the study include

(i) to ascertain the number of infant deaths in the past two years in the study area,

(ii) to identify the factors associated with these infant deaths, and

(iii) to develop a plan of action to reduce the number of infant deaths in this area.

Methodology :

The study has been conducted over a 3-month period in four Gram Panchayats (60 villages) covering 6000 households in Boudh block of Boudh district, Orissa. After enumeration of families where one or more infant deaths have occurred during the last two years, a hundred households were selected by simple random sampling and interviewed through a structured schedule.

Major Findings :

In this area 65 percent of households were Below Poverty Line and most of the mothers (71%) were illiterate. The deliveries mostly take place at home and were attended by relatives, un-trained Dais, and occasionally by trained Dais. Though babies born with a weight less than 2500 gm had high risk of neonatal death, post-neonatal deaths were a little more in above 2500 gm group (29%) than in the less than 2500gm group (23%). At the time of death 19 percent of children had suffered from fever or malaria and 25 percent from anaemia. Nearly 19 percent of infant deaths occurred to babies born with low birth weight and rest died due to lack of care. Due to lack of antenatal and post-natal care 71 percent of the infants were malnourished and repeatedly fell ill and were attended to by traditional healers.

Conclusion :

Proper antenatal care, nutritional supplements coupled with health education to expectant mothers, institutional delivery and effective postnatal care will reduce the infants' deaths.

Action Plan :

Therefore, capacity building of expectant mothers, TBAs, health functionaries and community leaders on the above-said issued has been planned.

B - CHILD HEALTH AND MALNUTRITION : CAUSES AND EFFECTS

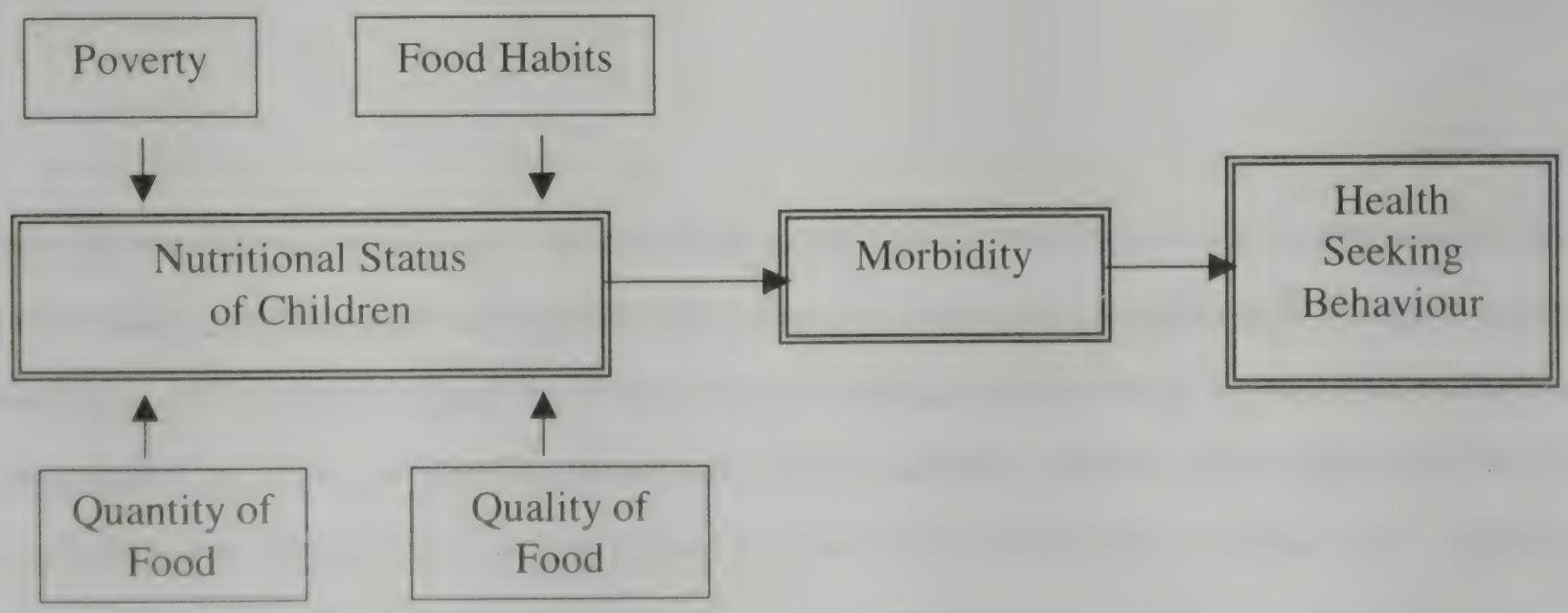
Introduction :

It would seem to be a truism that children who are fortunate to survive infant death now face an equally difficult time because they become malnutririoned. What is the real situation?

Nutritional status is a major determinant of the health and well being of children. Available statistics based on the NFHS II report indicate that almost 47 percent of children under 3 years of age are underweight and a similar percentage stunted. The proportion of children who are undernourished is around 18 percent for weight-to-age and 23 percent for height-to-age. This would be more applicable to the hinterland of the country. Malnutrition is the main cause of morbidity and mortality of infants across the country. Some of the factors associated with malnutrition include poverty, food habits and quality and quantity of food including hygienic condition. There are cultural practices related to breast feeding and weaning, which in turn compound the problem of malnutrition among infants. One of the major derivatives of malnutrition is the inadequate intake of Vitamin A, which invariably leads to blindness among children.

In remote parts of this country, such as tribal and backward rural areas in states like Orissa, Uttar Pradesh and Madhya Pradesh, the problem of malnutrition is very acute and children are exposed to disease and death. The present study focuses on these areas where there is acute malnutrition.

Conceptual Framework :



Based on the above reasoning, four studies have been undertaken. Their abstracts are presented below.

Factors Associated with Malnutrition Among Children aged 12-24 months

by

T. K. Mohanta, Centre for Regional Education, Forest and Tourism Development Agency (CREFTDA)

Background :

With adequate breast-feeding, the growth pattern is normal for the first few months of life. After that without proper weaning, the baby does not gain weight. The study by CREFTDA tries to bring out the underlying factors in its project area.

Objectives :

The main objectives are

(i) to ascertain the number of malnutrition infants in the study area.

(ii) to determine factors associated with malnutrition among the proposed target group, and

(iii) to develop an action plan to control malnutrition in the study area.

Methodology :

After preparing a complete list of all children in the Anganwadi centres, 116 out of 217 children in the age group 12 to 24 months were found to be malnourished. Except for 6 who have migrated, the rest of the mothers were interviewed with a structured schedule. Out of 110 children, male and female children were 44 and 66 respectively.

Major Findings :

In this area 86 percent of the households lived Below the Poverty Line and among them 40 percent had malnourished children. The girl child was more prone to malnutrition (43.9%) than the male child (31.8%). About 73 percent of mothers were illiterate and 43 percent of them had children in the nutritional status grade II or III, whereas among literate mothers only one fourth of children were in those grades. The nutritional status was better among the children whose weaning foods started from 5 months onwards. Although 98 percent children receive supplementary nutrition from Anganwadi centres, 38 percent of them were either moderately or severely malnourished. About 54 percent and 61 percent of children were suffering from diarrhoea and fever respectively and almost 50 percent of them were undernourished.

Conclusion :

Lack of education, poor economical condition, misconceptions about weaning practices and frequent fever and diarrhoea lead to malnutrition.

Action plan:

CREFTDA is planning to generate awareness regarding health and nutrition among the mothers and community members in this area. Then the findings of this study will be shared with Government and non-Government agencies to draw their attention to improve the situation of this area at a wider scale.

Factors Associated With Malnutrition Among Children Aged 12 –18 Months

by

Pramod Perua, Social Education for Women's Awareness (SEWA)

Background :

SEWA's observation that there was a high degree of childhood malnutrition in its project area resulted in it undertaking this study to gain more systematic information and thence to plan appropriate strategies to contain the phenomenon.

Objectives :

1. to ascertain the number of malnourished infants in the study area.
2. to determine factors associated with malnutrition of infants in the study area.
3. to develop an action plan to control malnutrition in the study area.

Methodology :

From the study area all children aged 12-18 months are weighted and graded by nutritional status. A 100 mothers with malnourished children were then selected through random sampling and interviewed using an interview schedule.

Major findings :

More female children, compared to male children, were more malnourished. Out of 16 normal grade children, female children constituted only one fifth of male children. Almost 50 percent of mothers were below 25 years of age, having 2 to 3 children and more than 50 percent of these children were severely malnourished. Severity of malnutrition was more among families belonging to poor economic status than to economically sound families. The health status of children growing under mother's care is much better than that of children cared for by grandparents. Source of drinking water is not a factor for malnutrition because more than 75 percent of families have hand pump. Just over half the families (51%) of mothers are illiterate and more of their children, compared to children of primary or secondary level educated mothers, are suffering from malnutrition. The health status of children growing within joint families is better than that of children in

nuclear families. The percentage of LBW babies in study area is very low (16%), but LBW children are more malnourished (62%) than normal babies (44%). Almost 50 percent of mothers started breast-feeding within 1 to 2 hours of delivery and also fed colostrums. Weaning was started before four months of birth for a majority with rice, dal and biscuits. These children were more malnourished than the children whose weaning started after 6 months. Though 86 percent had ICDS facility, only 50 percent of mothers and children received supplementary nutrition from it.

Conclusion :

Less birth spacing, poor economic condition, lack of mother's care, poor education level of mothers and lack of awareness about the weaning and exclusive breast feeding practice were the main causes of childhood malnutrition in this area.

Action Plan :

To control malnutrition of children through awareness programme for parents.

Breast-Feeding And Weaning Practices In Tribal Villages

by

Dr. Bimal Kumar Panda, Citizens' Association for Rural Development (CARD)

Background :

Irregular breast-feeding by working mothers, taboos and misconceptions related to colostrums and introduction of pre-lacteal feeds affect the health of children in tribal regions of Orissa. The present study details some of those factors.

Objectives :

The objectives include the study of:

(i) the practice of colostrums and breast-feeding among the mothers of 1 to 2 year old children

(ii) the weaning practice of children among the mothers of 1-2 years children, and

(iii) to develop an action plan to increase the awareness of the mothers for improvement of the practice of breast-feeding and weaning.

Methodology :

Enumerating all tribal mothers with children of 1 to 2 years of age, 160 mothers were found eligible for this study. Using Simple Random Sampling Method, 100 available mothers were interviewed with a pre-tested interview schedule.

Major Findings:

Most of the lactating mothers in this area belonged to the age group of 21 to 30 years. With poor literacy and abject poverty, an overwhelming proportion of women were employed as unskilled labour. Due to lack of adequate breast milk and mother's ill health, initiation of breast milk was delayed up to the third day. Mothers believed that colostrums intake is harmful for the child's health. Instead, they often preferred to give water mixed with sugar as pre-lacteal feed. Only 30 percent of the children were exclusively breast-fed up to 4 months of age. Since most of the mothers went out for work, they usually fed their babies with plain / boiled water, and *Handia/ Kwatha* as supplementary food. About 72 percent of the mothers gave their children cereals and green leafy vegetables as weaning food after 6 months.

Conclusion :

The malnourishment of children is the result of late initiation of breast-feeding, discarding colostrums and administration of pre-lacteal feeds and early introduction of supplements.

Action Plan :

To create awareness among the tribal mothers regarding appropriate practice of breast- feeding and weaning.

Child Health Care Practices Of Tribal Mothers Having Children Up To 2 Years

by

Kailash Chandra Palo, PRAGATI

Background :

In Rayagada District of Orissa, the infant mortality rate is 96 per thousand, which is higher than the Indian scenario (84.2 among scheduled tribe). Malnutrition as well as infection is the main cause of infant mortality that requires more in-depth studies in that tribal dominant district before developing any intervention programme.

Objectives :

The specific objectives include

(i) assessing the practice level of mothers regarding nutrition and immunization, and

(ii) developing an action plan to make the mothers aware about childhood illness, nutrition and immunization.

Methodology :

Enumeration of all mothers having 1 to 2 year old children in 32 alphabetically listed villages in two Gram Panchayats of Rayagada block was done. Using simple random sampling method, 100 mothers were selected and interviewed with a structured interview schedule.

Major Findings :

Mothers of this area considered colostrums as harmful for child's health. As most of the tribal mothers went out for work, they fed their newborn babies with plain / boiled water, biscuits, barley, and especially tinned or cow milk as supplementary food. They usually continued breast-feeding for more than one year and started weaning from six months after birth. High-income group people fed their children with rice whereas other group (96%) fed ragi as weaning food. About 17 percent of mothers were totally unaware of immunization. As far as Polio and DPT vaccines are concerned, the immunization status dropped drastically from the first to the third dose. Only 11 percent of the children were immunized against measles. More than half of the mothers did not give normal food during illness of their child, as they believed that children cannot digest it at that time.

Conclusion :

Improper breast-feeding practices, misconceptions regarding nutrition and incomplete immunization lead to malnutrition followed by infection among children.

Action Plan :

To generate awareness regarding immunization, appropriate breast-feeding practices and preparation of locally available nutritious food an action plan has been chalked out by PRAGATI.

C - ROLE OF PUBLIC AGENCIES: MEMBERS' PERCEPTION OF THEIR ROLE IN HEALTH PROGRAMMES

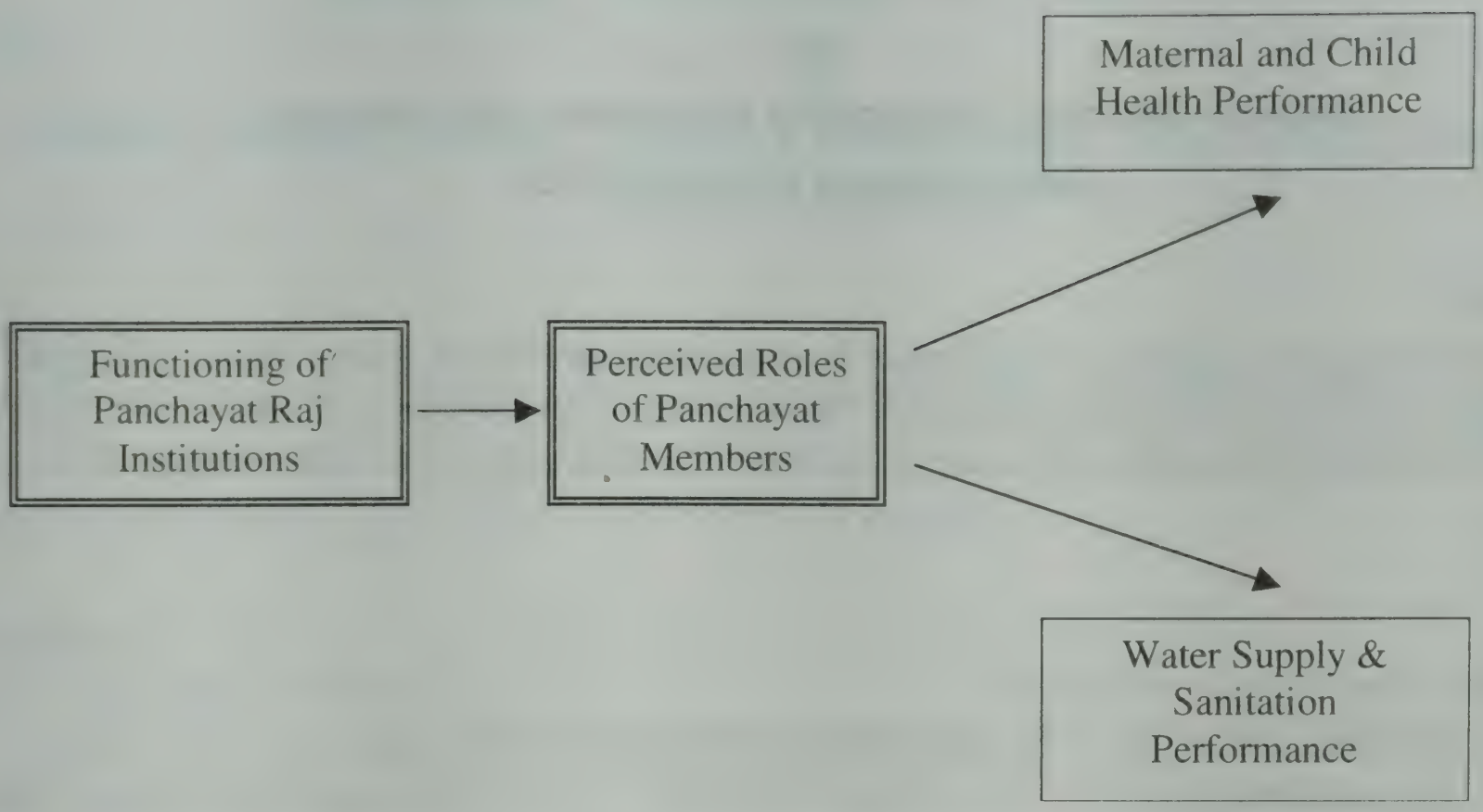
Introduction :

The recent amendment of the Constitution makes provision for a larger role for Panchayat Raj Institutions in the country. Some of the roles and responsibilities given to the Panchayat Raj Institutions include health and health-related activities such as maternal and child health, water supply and sanitation. State governments have taken an effort to transfer their responsibilities in these areas to Panchayat Raj Institutions. However it is felt that the people's representatives are still grappling with the new roles and responsibilities. Improvement of health status at present is in the hands of these people's representatives in Panchayat Raj Institutions. Therefore it is important to understand their characteristics and their perception of roles in implementing maternal and child-health and water and sanitation programmes. This will enable the government to strengthen the capacity of the Panchayat Raj Institutions to handle health and health-related activities to improve the health status of rural and tribal populations. To gain understanding of the perceived roles of Panchayat Raj Institutions by the people's representatives, the present study is undertaken.

To deal with this difficult problem of reaching out to the remote parts of the country, the government health system is working with local groups who are part of the community and can influence mothers to immunize their children. One such experiment is making use of self-help groups, which are already established in these backward areas to motivate mothers to bring their children for immunization. While in some areas these groups are taking interest in the immunization programme, in many other areas, they are more concerned about economic programmes rather than the immunization programmes with which they have been entrusted.

The questions in the above context are: to what extent are the representatives aware of their role and what do they actually do in reality. To answer these questions two studies were undertaken as seminal studies keeping in sight the following conceptual framework.

Conceptual Framework :


Maternal and Child Health Performance
Functioning of Panchayat Raj Institutions
Perceived Roles of Panchayat Members
Water Supply & Sanitation Performance

The major thrust of these studies was to:

(a) ascertain their level of awareness about the roles and responsibilities in Immunization and Safe Delivery Program, and

(b) to study the interest level of Women SHGs to improve the immunization status.

Following the above framework, the abstracts of the two studies are presented below.

Level Of Awareness About Key Health Programs Amongst Panchayat Representatives

by

Ameen Charles; Dayanand Dhuware, Community Development Centre (CDC)

Background :

While working on capacity building of Panchayat Representatives (PR) in Baihar Block, Balaghat, M.P., CDC has observed that community participation in Government health programs is very much negligible in the area. This led them to undertake this study on the level of awareness of the PRs in respect to key health programs.

Objectives :

Main objectives of the study are to find out:

(i) the characteristics of Panchayat Representatives interviewed in the study,

(ii) their level of awareness about the roles and responsibilities in Immunization and Safe Delivery Program, and

(iii) to plan an intervention strategy to improve the level of awareness.

Methodology :

Twenty Gram Panchayats (GP) have been selected randomly, from a sample frame of 65 GPs in the block. From these, 200 Panchayat members have been selected using simple random sampling procedure (20 Sarpanches and 9 Panches in each GP).

Major findings :

A majority of PRs are totally unaware regarding their roles and responsibilities in the Immunization (60%) and Safe Delivery (68%) Programs respectively . Sarpanches are better informed (45%) than the Panches (30%). Literacy is positively associated with awareness regarding both the programs. That experience as a Panchayat Member has significant influence only on safe delivery program is evident from the fact that respondents with eight years of experience are more aware (almost 50%) than those with three years experience (25%). Though sex of the Panchayat members has no influence on awareness level, the level effectively varies with different age groups, as younger members (48 %) are more aware than the older ones (30%).

Conclusion :

Overall awareness level of the Panchayat Members, who are responsible for the village people as their representatives, is not satisfactory.

Action Plan :

It will include developing of IEC materials and organizing training programs to build the capacity of the members and improve their awareness level.

Knowledge and Interest level of Members of Women SHGs about Universal Immunization Programme

by

Bhikari Charana Behera, People's Educational Action and Communal Evocation (PEACE)

Background :

Working among the people of Mohana block, Gajapati district, Orissa, PEACE found that the immunization status in the area is very poor. This led the NGO to undertake this study on Women Self-Help Group members on immunization and their involvement in the process.

Objectives :

The main objectives of the study are :

(i) to assess the knowledge level of the members of Women SHGs about the Universal Immunization Programme (UIP) and

(ii) to study the interest level of Women SHGs to improve the immunization status.

Methodology :

A sample of 107 Women SHG members was selected by systematic random sampling from a sample frame of 502 women members enrolled in the micro-credit cell of PEACE. Of the 107, 10 could not be interviewed. The interviews were canvassed with a pre-tested schedule.

Major Findings :

Nearly three out of every four respondents are illiterate (73%). Just over half of them belong to Scheduled Tribe (56%). Amongst them 42 percent have the requisite training on health issues. But they have a very little knowledge regarding DPT (22%) and Vitamin A supplements (39%). Illiterate members are almost unaware about Diphtheria (97%), Whooping Cough (93%) and have little knowledge about Tetanus (65 %) and Vitamin A (69%). Though Women SHG members motivated people to increasingly avail of immunization (94%), yet just over half of them (53%) have started it very recently. Though participation rate of Women SHGs in the programme is satisfactory (83%), yet only 25 percent have organised any immunization camp and only 4 percent of them initiated discussion on the same in any meeting.

Conclusion :

The knowledge and interest level of the women SHG members of the study area are not satisfactory.

Action Plan :

Capacity building of Women SHG members are planned with development of better IEC materials and involvement of different stakeholders.

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OVERVIEW

Reviewing the various studies that have been done and reported, the overall picture that emerges is a
follows:

A. Infant deaths:

Infections during pregnancy, poor pre and antenatal care, lack of nutritional supplements, high level o
ignorance of expectant mothers, seem to be the main causes of infant deaths.

B. Malnutrition

Again, lack of education coupled with misconceptions about weaning practices and frequent fever and
diarrhoea lead to malnutrition. Additionally, inappropriate birth spacing and lack of mother's care also causes
of childhood malnutrition in this area.

Late initiation of breast-feeding, discarding colostrums and administration of pre-lacteal feeds and early
introduction of supplements, improper breast-feeding practices, misconceptions regarding nutrition and
incomplete immunization have also been reported to lead to malnutrition followed by infection among children.

C. Public Agencies

Finally, public servants as well as those of volunteer self help group members' awareness level is not
satisfactory.

II : ADOL ESCENT HEALTH AND RELATED ISSUES

1. Menstrual Hygiene and Associated Problems Among Adolescent Girls
   Prakash Kulkarni, Janaseva
2. Level Of Knowledge On Sexual Health Education Among Unmarried Adolescents
   Pradeep Kumar Sahoo, Maitree
3. Knowledge and Sexual Behaviour of Unmarried Tribal Adolescents
   Jagdish Chandra Sahoo, MY-HEART,
4. Reproductive Health Problems Of Unmarried Adolescent Girls
   Rupashree Dash, OMRAH
5. Knowledge And Attitude Related To Reproductive Health Of Adolescents.
   Jameela George, SHARE
6. Utilisation Pattern Of Reproductive Health Services By Tribal Adolescent Girls
   Pravat Kumar Satapathy, USO
7. Problems of Adolescent Girls among Migrant Labour Population of Industrial Slum Pockets
   Reeta Sahu, USS

OVERVIEW

REPRODUCTIVE HEALTH PROBLEMS OF ADOLESCENTS

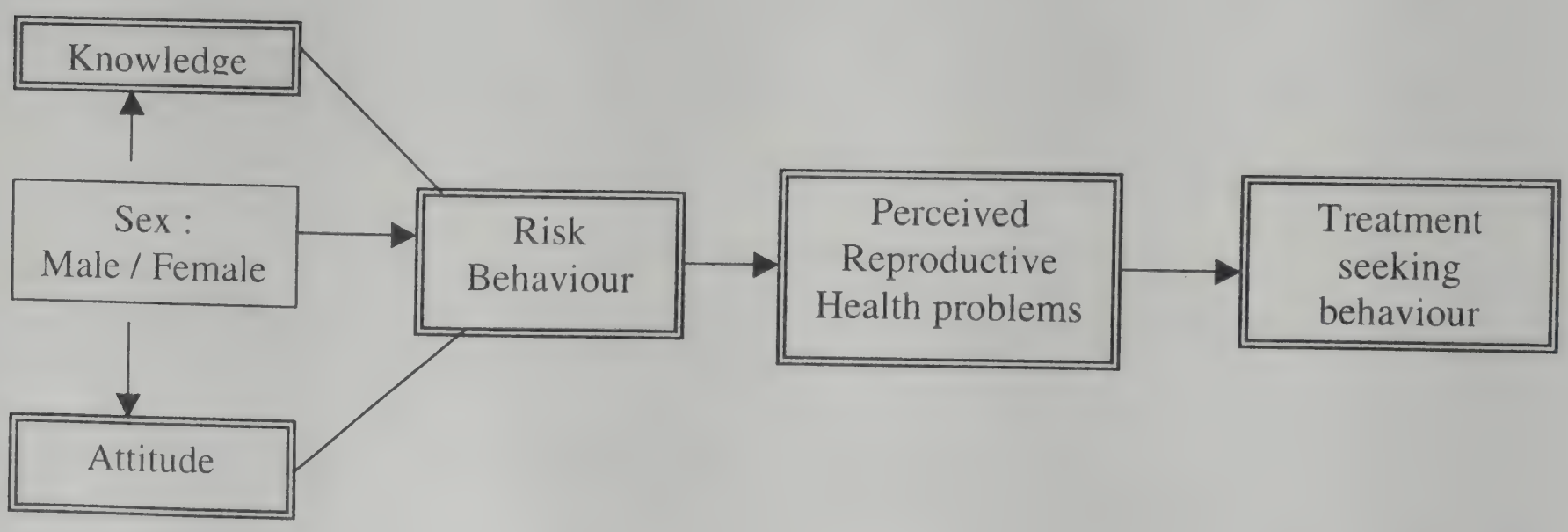
Introduction

It is estimated that there are around 200 million adolescents (10 – 19 years) in India. There is gende disparity in the adolescent population in terms of morbidity and mortality. This disparity is largely explained by poor reproductive health. Adolescent girls are disadvantaged in terms of education, food intake and access to health care. A sizeable proportion of tribal, rural and slum adolescent girls marry during this stage, making them vulnerable to maternal morbidity and mortality.

Adolescents tend to be poorly informed regarding their own sexuality and physical well being. Awareness among female adolescents about menstruation and other changes at puberty tends to be low. This is particularly true among younger adolescents. Lower rates of education attainment, limited sex education and inhibited attitudes towards sex, limit their knowledge related to reproductive and sexual health.

Considering the poor knowledge, attitude and behaviour of reproductive health among adolescents, there is need for appropriate interventions to introduce a strategy to combat reproductive health problems among adolescents. First of all, we need more authentic information about their knowledge, attitude, behaviour and its effect on reproductive and sexual health. Further, we need to know their health seeking behaviour when they face reproductive and sexual health problems. The studies focus on all these aspects so that appropriate strategy and interventions may be initiated.

Conceptual Framework :



Objectives :

The general objectives covered in these studies are given below.

1. to determine the level of knowledge and attitude of adolescents regarding reproductive health issues
2. to study the nutritional practices, reproductive health hygiene behaviour and unprotected / unsafe sexual behaviour of adolescents
3. to identify the perceived reproductive health problems and its associated factors among adolescents
4. to find out treatment seeking behaviour related to reproductive health problems of adolescents.

The above objectives are dealt in 7 micro studies conducted in different parts of the country. The studies cover tribal, rural and urban slum areas. Thus these studies form one multi-dimensional and multi-centric study of reproductive and sexual health issues of adolescents drawn from tribal, rural and urban slums across the country. Given this thrust, this study is a mosaic of sub groups of population taken from different parts of the country and simultaneously compares the reproductive and sexual health issues of these sub-groups.

The primary data for the project were collected through direct interviews with a representative sample of the target groups using a pre-structured, pre-tested interview schedule. The location from which the sub-groups of respondents are being drawn and the respective sample size is given below.

Target Population	Target Area	Sample size
11 – 19 years tribal girls	Uttaranchal	126 tribal girls
13 – 19 year tribal boys and girls	Tribal Orissa	50 tribal boys and girls
13 – 16 years rural girls	Maharashtra	100 rural girls
13 – 19 years rural girls	Orissa	100 rural girls
13 – 19 years slum girls	Orissa	100 slum girls
10 – 19 years rural girls	Orissa	100 rural girls
10 – 19 years tribal girls	Orissa	120 tribal girls

The field study was undertaken by seven NGOs who were actively working in the field of adolescent health in these geographical locations. Abstracts of these studies are now presented below.

Menstrual Hygiene And Associated Problems Among Adolescent Girls

by

Prakash Kulkarni, Janaseva Foundation

Background :

Studies have shown that adolescent girls in rural areas continue harbouring misconceptions and myths about menstruation, and continue menstrual practices, which lead to infections of the reproductive tract. A simple education programme targeted at adolescent girls will reduce the morbidity associated with menstrual cycle considerably. The Janaseva Foundation is planning such an education programme for adolescent girls in rural areas, and to this end has initiated this study on the menstrual practices of the adolescent girls in two schools in Panshet Block.

Objectives :

The objectives of the study were:

(1) to find out the proportions of girls suffering from menstrual problems,

(2) to ascertain the level of awareness of adolescent girls about menstrual hygiene practices,

(3) to determine the menstrual hygiene practices in the girls, and

(4) to plan an intervention strategy for improving the menstrual hygiene among adolescent girls.

Methodology :

The Study was conducted in 2 Villages, Panshet and Khanapur, where the Foundation has contacts with local schools. Out of the 412 girls in Standards 8 to 10 in the two school, fifty were randomly selected from each school. Thus, a total of 100 girls were selected from the 2 villages. Each girl was then administered a pre-tested questionnaire in the vernacular language.

Major Findings :

Except for two girls, all others had attained menarche. Of them, 72 percent attained menarche by the age of 12 years. All of them had normal cycle of menstruation. Different problems during menstruation were mentioned by the respondents. Many of them suffered from more than one problem. While 71 percent suffered from abdominal pain, 52 percent complained about backache. Scanty bleeding was reported by 39 percent of the respondents. All these problems were found to be more among the older adolescents than with the younger ones.

Action Plan :

The Organization is planning to develop a School Based Programme, which will address these issues.

Level Of Knowledge On Sexual Health Education Among Unmarried Adolescents (10 To 19 Years)

by

Pradeep Kumar Sahoo, Maitree Yuva Sansad,

Background :

Maitree, an NGO, was interested to find out the impact of its educational programme, and specifically on educating adolescents on sexual health. Maitree's intention is to improve the programme further. Hence this study was initiated by it.

Objectives :

The objectives of the study include

(1) assessing the level of knowledge of the adolescents on sexual health,

(2) finding out the factors associated with the level of knowledge of the adolescents on sexual health,

(3) preparing an action plan to implement a sex education programme for adolescents.

Methodology :

One gram panchayat (GP), Bhatasahi G.P of Nayagarh Block, Nayagarh district in Orissa, with a population of 3181 was selected for this study. The total adolescents of the area are 463 persons. Using simple random sample method, 100 out of the 463 adolescents were selected. An interview schedule was used to collect data.

Major Findings:

Only 25 percent of the adolescents had knowledge about the problems and consequences of premarital sex. Knowledge of sexually transmitted diseases was found to be low. Sixty percent had knowledge about HIV/AIDS. Only 29 percent knew about safe sex, and of these 83 percent said that use of condom was a safe sex method. Only 19 percent had knowledge about menstrual health. Knowledge on consequences of early pregnancy was as low as five percent. Though 45 percent of the respondents were aware of reproductive health problems, 91 percent among them did not know the causes and 88 percent did not know the consequences of reproductive health problems. Knowledge about unsafe abortion was found to

be five percent only. On the whole, the adolescents had very low knowledge about reproductive and sexual health. Eighty four percent of the respondents attributed the low level of knowledge to the barriers imposed by their parents to acquire such knowledge.

Action Plan

The five point action plan is:

- Collection of IEC materials from health departments and free distribution among adolescents.
- Conduct a workshop for the school staff.
- Awareness meeting on adolescent health in the community.
- Taking at least 2 sessions on adolescent health for school-going adolescents.
- Strengthen PTA towards adolescent health education.

Knowledge and Sexual Behaviour of Unmarried Tribal Adolescents

by

Jagdish Chandra Sahoo, March of Youth for Health, Education and Action for Rural Trust (MY-HEART)

Background:

Compared to the general population, tribal people have their unique lifestyle. Some tribes are more open towards premarital and multiple sexual partners. They are more open towards premarital sex beyond the four walls, and this behaviour leads to health problems including infant death, unintended pregnancy, unsafe abortion, STIs, and RTIs. To address the health problems, especially reproductive health problems, MY-HEART has been implementing the RCH (Reproductive and Child Health) programme. During the intervention, the organization has found some evidence of frequent unsafe abortions, with some deaths also, among the unmarried adolescent girls. STIs and RTIs are also high among the people. The existing sexual practices and knowledge among the unmarried adolescents need to be understood to address their reproductive health problems. Hence this study was undertaken.

Objectives :

The objectives of the study include,

(1) finding out proportion of adolescents indulging in unprotected / unsafe sexual behaviour,

(2) studying the nature of sexual behaviour of unmarried adolescents,

(3) assessing the level of knowledge of adolescents on protected / safe sexual behaviour, and

(4) developing need-based IEC strategy to promote safe sexual behaviour.

Methodology :

The study was conducted in the district of Deogarh, Orissa. There were 1020 adolescents in the age group of 13 to 19 years in the target area, who formed the sampling frame. It was decided to select 50 of them by simple random sampling method and then to interview them. A pre-tested interview schedule was prepared for data collection. Data was collected in October and November 2002.

Major Findings :

The data clearly showed a high percentage of sexual activeness including penetrative sex from an early age. Most of them had partners from the opposite sex, and a significant proportion of them had multiple partners. Most of the adolescents had little knowledge about STI and RTI, its symptoms, causes and modes of transmission and safe sex practice. Though they had the requisite knowledge about use of condom to prevent STI, they did not practice 'safe sex' in reality. Though they had the knowledge about barrier methods, their use in sexual act was very low. These data showed the high percentage of high-risk sexual behavior. They had knowledge about safe abortion and place of abortion, which clearly implied the high prevalence of unintended pregnancy among the unmarried girls. While boys had better knowledge of barrier methods, girls had better knowledge about abortion service providers.

Action Plan :

Sexual health education training would be conducted separately for both sexes. Adolescent health mela would be conducted for massive awareness generation. Innovative competitions regarding sexual health would be conducted. In addition, STI and RTI check-up and interpersonal counseling session would be held for them. For this, a counseling cell would be opened for them. Education session for parents on adolescent sexual health would be conducted to make them aware how to address their young children's sexual problems.

Reproductive Health Problems Of Unmarried Adolescent Girls (13-19 Years)

by

Rupashree Dash, Orissa Institute of Medical Research And Health Services (OMRAH)

Background :

From its field experience in the target community OMRAH observed:

(1) that a majority of the girls were unaware about the process of growing up, because of social restriction of discussing freely about sex and sexuality.

(2) parents and family elders lacked adequate knowledge and communication skill to transfer information relating to reproductive ill health and sexual problems that arise during adolescent period.

(3) adolescent girls lack awareness regarding reproductive and sexual health problems that may occur during adolescent period.

(4) inaccessibility of appropriate health care to cater to the needs of adolescent girls.

(5) girls lack self-confidence and assertiveness, which has a negative influence in developing positive health seeking behavior.

Objectives:

The objectives of the study included:

(1) identifying the reproductive health problems among unmarried adolescent girls,

(2) finding out the factors associated with reproductive health problems,

(3) assessing their level of knowledge about reproductive health problems and

(4) preparing an appropriate IEC strategy for unmarried adolescent girls.

Methodology:

The study was conducted in 10 villages of two Gram-Panchayats of Nischintkoili block of Cuttack district in Orissa. From the sample frame of 663 unmarried adolescent girls in the 10 villages, a sample of 100 to cover all the villages was selected by systematic sampling with a random start.

A pre-tested interview schedule was used for data collection. Four specially trained Investigators, guided by a competent Research Supervisor, collected data from individual respondents between October and December 2002.

Major Findings :

A majority of 77 percent were between 16 and 19 years of age. A majority of 60 percent of the adolescent girls were educated up to secondary level. Nearly a half of them i.e. 43 percent, belonged to the lower income group of less than Rs. 1,000 per month. A large majority of 85 percent suffered from different kinds of reproductive health problems. Reproductive health problems were more among the illiterates and low-income group adolescents. Menstrual hygiene knowledge and practice was poor. Ninety percent used cloths and simply washed these with water for reuse. A majority of 74 percent of the unmarried adolescent girls were aware of reproductive health problems but a majority of 54 percent did not know the causes and consequences of reproductive health problems. Ten percent of the unmarried adolescent girls were sexually experienced. A majority of 76 percent of the girls were aware of different consequences of teenage pregnancy. Over half of them (56%) were not aware of dangers of unsafe abortion. Only 44 percent of the respondents were aware of RTI and STI. On the other hand, 95 percent were aware of HIV/AIDS. Only 35 percent of the girls were aware of safe sex. Among them 77 percent said that condom should be used for safe sex.

Action Plan :

OMRAH decided to undertake an innovative programme to create awareness about sexual and reproductive health problems to help the target population and take up preventive measures. Specific programes include:

(1) Health camps to be organized to identify reproductive health problems and to treat them.

(2) Awareness campaigns to be undertaken in schools and working places of the unmarried adolescent girls.

(3) Advocacy meetings and discussions will be initiated with community leaders, local health professionals, social animators and opinion leaders.

(4) Adolescent groups shall be formed for a continuous and convenient learning from IEC materials.

(5) Life skill education and family life education would be undertaken for the unmarried adolescent girls.

(6) OMRAH will undertake the task of developing IEC materials focusing on reproductive and sexual health among adolescent girls.

Knowledge And Attitude Related To Reproductive Health Of Adolescents.

by

Jameela George, Service for Health and Rural Education (SHARE)

Background :

Focus group discussions conducted in the area revealed that premarital sex is practiced and adolescent's experiment with sex when they are as young as 13-14 years old. To deal with the sexual health of the adolescents, 30 adolescent groups for boys and girls were formed and were trained in reproductive health issues. The feedback obtained from the staff and adolescents was very encouraging. Therefore, SHARE intends to form more groups and expand the work. For this, research was planned to study the knowledge and attitude of the adolescents regarding select reproductive health issues. The findings would reveal how effective the training was and the areas that need improvement.

Objectives :

The objectives of the study include

(1) determining the level of knowledge of adolescents regarding select reproductive health issues,

(2) ascertaining the attitude of adolescents towards select reproductive health issues,

(3) assessing the association between level of knowledge and attitude on the one hand and select characteristics of respondents on the other and

(4) applying the findings of the study in implementing adolescent program in Jaunpur Block of Tehri Gharwal District

Methodology :

The study was conducted in Jaunpur Block of Tehri Garhwal District, in Uttaranchal with a population of 10,500. There were 295 adolescent boys and girls trained and they formed the sample frame. Out of the 15 villages where training programmes were conducted, 8 villages were selected by using simple random sample method. All the 126 available trainees in the sample villages were interviewed using a pre-tested interview schedule.

Major Findings :

A majority of 74 percent of the adolescent boys and girls were aware of the age at which girls could marry.

A larger proportion of the older and wealthier adolescents than others were aware of the age at marriage for girls. While a minority of 37 percent of boys were aware that a girls could become pregnant in the first sexual intercourse, a large majority of 83 percent of the girls were aware of the consequences of first sexual contact. Only 24 percent of the boys and 49 percent of the girls were aware that a girl could become pregnant even if she washed her vagina after sexual contact. Many adolescent girls (49%) believed that if the man assured her that she would not become pregnant, she would never become pregnant. On the whole, both boys and girls had many misconceptions about safe sexual behaviour and health. A majority of the adolescents did not have proper knowledge about antenatal care services. Girls had better knowledge than boys. Regarding family planning, more boys than girls, more of the wealthy than poor and more of the educated than illiterate had better knowledge. While 67 percent of the boys had correct knowledge of family planning, only 45 percent of girls had such knowledge. Boys (91%), than girls (68%) knew better about HIV/AIDS. However, better educated girls had higher knowledge about HIV/AIDS.

From an attitudinal perspective, many believed that girls need not be fed like boys and they need not be educated like boys. However, wealthy adolescents had more positive attitude than the poor adolescents in this regard. A majority of them felt that it is not correct to have friends from the opposite sex. As age increased, the belief that one need not be faithful to one's partner increased.

Action Plan :

The action plan as implemented till end October 2003 and intended to be completed in due course is as follows :

1. Training of staff involved in adolescent program

A one- day training program was conducted on17.10.03 at Mussoorie. 9 staff involved in the adolescent program and a project manager were trained. Ms. Jubin Vargese, a psychologist was the resource person. The topics discussed were:

a. Value statements on adolescents
b. Psychological changes in adolescents
c. Adjusting to physical changes
d. Emotional development during adolescence
e. Cognitive development during adolescence
f. Risk reduction – HIV/AIDS

2. Topics to be included in adolescent manual badthe katham

   a. Risk reduction

      - Risky behaviour – Safe sex, low risk, unsafe sex
      - Causes of risky behaviour

   b. Sexual behavioural change

      - Stages of change
      - Individual level behavioural change
      - Community level intervention
      - Promotion of safer sex

3. Books I have read to prepare the above mentioned topics:

   a. Training of Peer Educators – in STD & HIV/AIDS prevention by APAC

   b. Facing AIDS together – HIV/AIDS prevention and care by World relief

   c. Promoting safer sexual behaviours by National AIDS program management

   d. Sexual behavioural change for HIV by UNAIDS

Utilisation Pattern Of Reproductive Health Services By Tribal Adolescent Girls (10 To 19 Years)

by

Pravat Kumar Satapathy, Universal Service Organisation (USO)

Background :

Universal Service Organization (USO), a development organisation was initiated during the year 1980 with intervention on drought mitigation in Danagadi Block of present Jajpur District of Orissa. In the study area, USO is working with "Kondhs", one of the most primitive tribes of the country. It is found that majority of the adolescents report to traditional practitioners and quacks for treatment of reproductive health problems. The Kondhs are slowly getting away from traditional practice. In this context, it is important for USO to undertake the research study to gain understanding of the complex utilization pattern of reproductive health services

Objectives :

The objectives of the study include

(1) identifying the reproductive health (RH) problems,

(2) studying the health seeking behaviour for reproductive health problems,

(3) finding out the factors associated with health seeking behaviour and

(4) preparing an action plan to deal with the reproductive health problems.

Methodology :

The study was conducted in the Kondh community in Badakhilapadar and Mukundupur Gram Panchayats (GPs) of Kolonara Block of Rayagada District, Orissa. A 10 percent sample of 120 adolescent girls from an estimated sample frame of 1,200 was selected using simple random sampling method. Thus, 60 girls in each GP were selected. An interview schedule was used for data collection

Major Findings :

The average age of achieving puberty is 11.6 years. Out of a total sample of 120 adolescent girls, 19.7

percent were married. Most of them (90%) were suffering from reproductive health problems and many of them had multiple reproductive health problems. There was considerable delay in reporting reproductive health problems, and 48 percent reported reproductive health problems when it was unbearable for them. Nearly 89 percent sought treatment. For first contact for reproductive health problems, 41.5 percent sought private practitioners (quacks) and 40.5 percent sought village medicine women. Only 15 percent of the respondents sought governmental institutional health care centres for first contact. But the percentage of those seeking institutional care increased to 33.7 percent, as the respondents continued to seek treatment to alleviate their reproductive health problems. On the other hand the utilization of private practitioners came down to 36.2 percent and that of village medicine women came down to 11.6 percent. Of the 30 respondents who did not seek treatment, 87 percent did not have financial resources to seek treatment.

Of the total sample, 60.5 percent were sexually experienced. Of them, 29.6 percent belonged to the very young age group of 10 to 12 years and a majority of 60.5 percent were in the age group of 13 to 16 years. Of those who were sexually experienced, 60.6 percent had sex with their would-be husbands and 21.1 percent had sex with their relatives. A good proportion of 38.1 percent reported pregnancy before marriage. Thirty one (31) respondents reported carrying out abortion of whom, 23 had abortion before marriage. Only 9.1 percent went to a government facility for abortion. The major provider of abortion service was the "village woman who conducts abortion", to whom 48.8 percent went for abortion.

Action Plan

Sl. No	Activities	Target	Strategy
A.	General awareness camps at community level (Quarterly)	36 camps	General meeting, poster presentation, Daskathia, video show
B.	Workshop of Government, Private health care providers and PRIs	2 days workshop for 30 x 2 nos.	Planning, sharing, review and problem analysis
C.	Awareness cum reproductive health camps for adolescents (Quarterly) cluster wise	6 camps x 3 quarters = 18 camps	Treatment by Doctor , IEC, counselling
D.	Wall paintings	18	Involvement of PRIs

Problems of Adolescent Girls among Migrant Labour Population of Industrial Slum Pockets

by

Reeta Sahu, Utkal Sevak Samaj (USS)

Background :

Many migrant adolescent girls living in industrial slum pockets of Jagatpur and Choudwar of Cuttack District Orissa with their family and also some times alone are facing sexual harassment from their relatives friends, and some times from outsiders. Additionally they suffer from menstrual health problems including high level of reproductive tract infection and sexually transmitted infection among the adolescent girls.

These problems came to light when the USO staff visited them in a programme supported by State Aids Cell on STD care. Hence the decision to study this phenomenon systematically and in some detail.

Objectives :

The objectives of the study include

(1) assessing the magnitude of RTI, STI and menstrual health problems encountered by adolescent girls in the proposed area;

(2) finding out health seeking behaviour related to RTI, STI and menstrual health problems of adolescent girls of the proposed area; and

(3) designing appropriate strategy for effective intervention in tune with the above objectives.

Methodology :

The study covers adolescent girls in the age group of 13 to 19 years living in 14 slums of Choudwar and Jagatpur industrial slums of Cuttack District, Orissa. Using simple random sampling method from the sample frame of 450 girls, 100 girls were selected for the study. An interview schedule was used to collect the relevant data.

Major Findings :

Nearly half the responding girls (48%) were young adolescents in the age group of 13 to 15 years. A majority of 61 percent were illiterates; 63 percent were labourers; and 59 percent had a household income of less than Rs. 1,000 per month. A majority of them had menstrual problems such as dysmenorrhoea (64%), and lower abdomen pain (78%). Many were suffering from RTI and STI and had reported complaints like white discharge (42%) and lower abdomen pain (60%). For these problems, 78 percent of the adolescent girls consulted their friends and only 8 percent consulted their mothers. A majority of 64 percent did not seek any treatment. A private practitioner (quack) was the main provider (32%) of reproductive health services. Only three percent approached the government health services for treatment.

Action Plan :

- **Behavior Change** through Interpersonal Communication, Group discussion, Peer group formation, SHG group formation, Training progamme for peer groups, Training programme to SHG group
- **Health Care** through Mobile health camp, Referral system, Counselling, Condom promotion.
- **Create A Supportive Environment** through SRAMADAN, SIBIR Literacy campaign

OVERVIEW

Of the seven studies that were undertaken, three were carried out in tribal areas, three in rural areas and one in an urban slum. The studies showed that the girls attained puberty by the age of 12 years. In all the studies, there was high prevalence of reproductive health problems and menstrual health problems. Knowledge of and attitude towards various aspects of reproductive health problems were low. Knowledge and attitude improved with higher education and income. Knowledge about HIV/AIDS was better than other reproductive and sexual health problems. One study attributed the low knowledge of reproductive health to their parents who constrained them to gain information about these problems, their causes and consequences.

The studies showed that premarital sex was prevalent in the study areas and they did not use any barrier method to avoid pregnancy. Especially tribal areas reported higher proportion of premarital sex. The study on Kondh tribes reported as high as 60 percent of the adolescent tribes were sexually experienced. One study showed the misconceptions about sex and male-female relationship. There were many cases of pregnancy before marriage and higher incidence of abortion among the tribal. These abortions were conducted by women in the village. Thus the adolescent is exposed to major health problems.

While in rural communities, adolescent girls reported their reproductive health problems to their mothers, in urban slums the girls shared their problems with their peers. For the reproductive health problems, the adolescents went to local medicine women or unqualified medicine women. Very few went to the qualified medical practitioners or government healthcare facilities. But when the problem persisted, the adolescents moved to government healthcare facilities.

From the findings of all the 7 studies, it is clear adolescent reproductive health problem is a serious problem, which is neglected till recently in national health programmes. Even now, the adolescents living in slums, villages and tribal areas do not have access to knowledge on reproductive health. They still depend on quacks to deal with their reproductive health problems. It is increasingly clear that premarital sex is emerging as a problem because the adolescents are not aware of safe sex. As a result, there is problem of pregnancy before marriage and abortions conducted by quacks.

The 3 tribal studies brought out that the tribal adolescent health problems are going to be a major issue in the country. Due to their traditional cultural practices of "open sex", it has created serious reproductive health problems in the modern age for them. With development activities taking place in their habitat, there are modern economic activities, which bring outsiders in their areas. The adolescents are sexually exploited by non-tribal population, who have migrated alone temporarily. Therefore, there is a need to give special emphasis to tribal adolescent health in the Reproductive and Child Health Programme of the government.

III : WOMEN'S HEALTH AND RELATED ISSUES

1. Utilization of Maternal Care Services among Tribal Women
   Saroj Kumar Dash, Pallishree

2. Nutritional Anemia in Married Tribal Women in Reproductive Age Group
   Vijaya Brahme, SMF

3. Prevalence of Reproductive Tract Infections and Associated Factors in Married Women
   Abdul Jabbar Sheikh, Nagrik

4. Prevalence of Reproductive Tract Infection and Associated Factors in Married Women
   Nitin Pawar, Rashikashraya

5. Prevalence of Gynaecological Disorders Among Adivasi (Tribal) Women
   Sailendra Narayan Das, SPARDA

6. Male Involvement in Maternal Health Care
   Jagannadha Sahu, SERVE

7. Comparison Of The Levels Of Knowledge And Attitude Towards Select Health Issues Of Illiterate Women Who Have Undergone Literacy Program With Those Who Have Not
   Vinita Chacko, Tushar

OVERVIEW

HEALTH PROBLEMS OF PREGNANT MOTHERS AND UTILIZATION PATTERN OF MATERNAL HEALTHCARE SERVICES

Introduction :

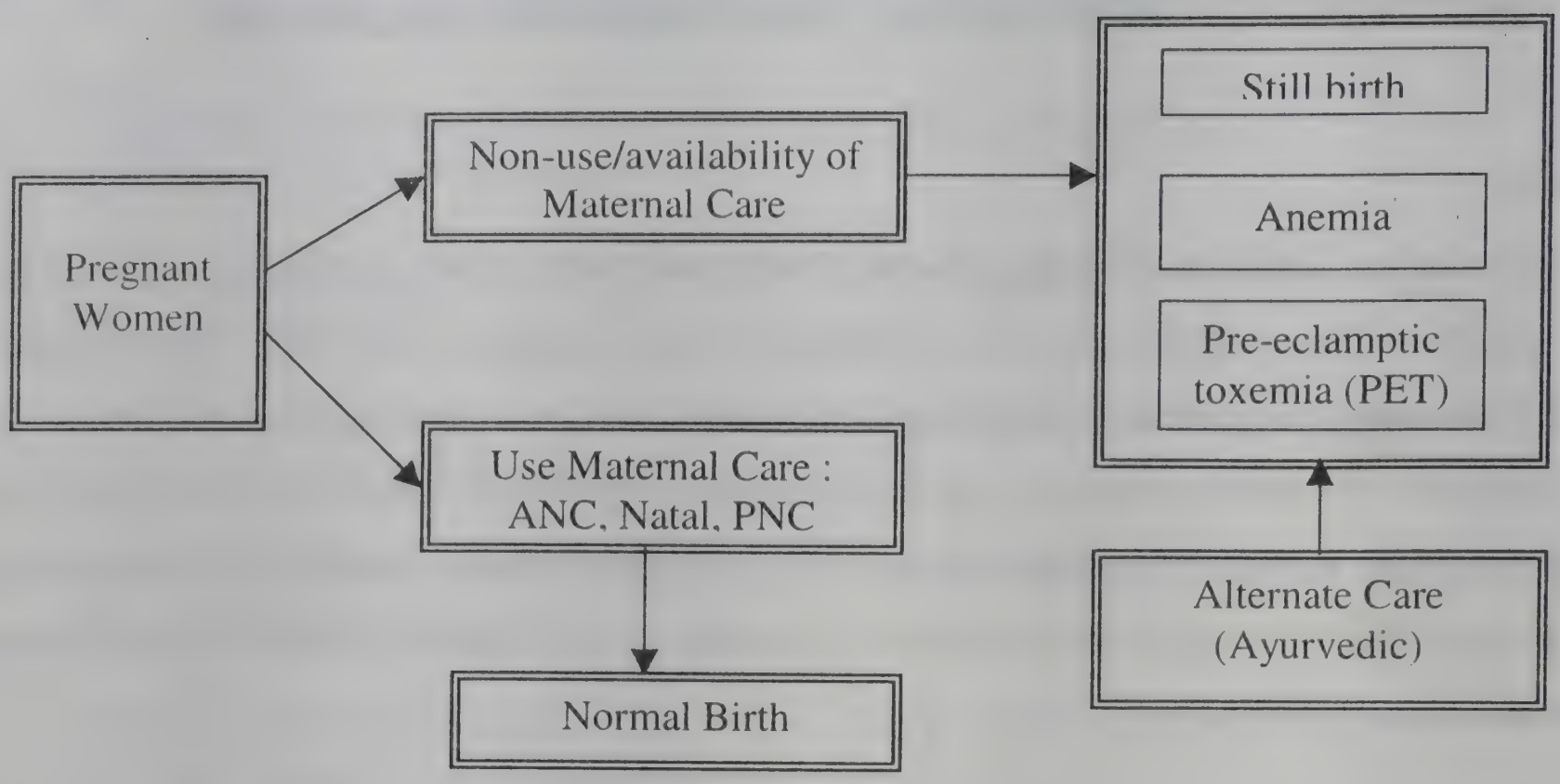
Government of India has established a wide network of maternal health care for pregnant women all over the country. Inspite of the availability of such facilities, still the utilization of such services lag behind expectations. First of all, the registration for antenatal care is not very encouraging, especially in rural and tribal areas. Many do not find the need for registering during pregnancy for antenatal check ups. Even those who register, they approach the health center only at the third trimester, mainly to avail the delivery facilities. As a result, they do not get the advantage of periodical medical checkup, tetanus toxoid injection and iron tablets.

It is observed that anemia during pregnancy is very high in poor population such as rural poor, tribal and urban slums due to poor intake of food, lack of food supplements and the low acceptance of iron tablets. There are misconceptions and cultural beliefs regarding food intake during pregnancy. There are certain taboos to take certain kind of food. Further, due to poverty, these pregnant women do not get adequate quantity of food. Pregnant women have misconceptions about iron folic acid. They also fear side effects of the tablet. In this context, it is worth looking at alternatives, which are more acceptable to tribal women. Since they are accustomed to herbal medicine, Ayurvedic drugs providing iron supplement may be one of the options for dealing with anemia.

Further, only a minority of pregnant women go for institutional delivery in the country. Another small proportion of pregnant women are attended by trained birth attendants at home. In rural and tribal areas, still majority of the deliveries are attended by untrained persons, normally friends and relatives. This has serious health implications leading to infant and maternal deaths. Postnatal health care utilization is extremely low. Only when there is some health problem for the child or mother, the health center is approached for services.

The above-mentioned issues during pregnancy are quite complex and they are intertwined to each other. The present study would like to explore these complex issues, which will contribute for better utilization of maternal care by pregnant women.

Conceptual Framework :



Objectives :

1. to study the utilization pattern of ANC, Natal and PNC services
2. to find out the proportion of maternal health problems, among pregnant women
3. to find out the prevalance of RTIs and factors associated with maternal health problems.
4. to ascertain the role of males in deliveries in inaccessible areas.
5. to find out the outcome of training women in various aspects of sexuality.

The abstracts of seven studies that were done to cover these objectives are now presented.

Utilization of Maternal Care Services among Tribal Women

by

Saroj Kumar Dash, Pallishree

Background :

Maternal mortality and morbidity in Orissa is high as 22 percent. Population is tribal, living in inaccessible villages, with low level of literacy and poverty. NFHS - 1998 indicates that women face problems during pregnancy such as night blindness, convulsions, swelling of the legs, body or face, excessive fatigue, anaemia, multiparity, etc. Other causes of vulnerability are hard work, poor nutrition, poor living conditions and under-utilization of maternal care services during pregnancy. Pallishree undertook a study on utilization of maternal health services by pregnant tribal women in Orissa.

Objectives :

1. to study the nature of utilization of Ante Natal Care (ANC), Intra Natal Care (INC) and Post Natal Care (PNC) services.
2. to study the factors associated with utilization pattern of maternal care services.
3. to develop a proposal for effective maternal care services.

Methodology :

The study was conducted in 24 tribal villages in a randomly selected sample of 100 out of 202 Munda and Santhal women who had given birth during the last one year. Using a pre-tested interview schedule, 100 women were interviewed regarding utilization of ante, intra and post-natal services and problems related to accessing maternal health services.

Major Findings :

The study indicated poor utilization of maternal health services by pregnant women in the study area. Registration for ANC was a low 53 percent, only 11 percent got registered in the first trimester. There was very low utilization of antenatal health care services. There was a high degree of ignorance among pregnant women about various health services they are supposed to use during pregnancy. Deliveries were attended mostly by husbands, untrained women, and untrained dais. A large proportion of women (53 %) suffered complications during delivery, such as, prolonged labour 30 percent, excess bleeding 14 percent, obstructed

labour 7 percent. Postnatal care services were also poorly utilized. Women went for postnatal care only when they had pregnancy-related complications or illnesses. Apart from lack of awareness, financial considerations and geographical distance acted as barriers to utilization. Women's education did not seem to have an effect on utilization, but husband's education had a positive influence on utilization of health services. Further, higher household income led to better utilization of maternal health services.

Conclusion :

The utilization of ANC and PNC services in tribal villages is low. Most pregnant women are delivered by their husbands or untrained TBAs. Lack of awareness, illiteracy and inaccessibility of maternal services are associated with this problem, which planners need to take into account during future planning of RCH services.

Action Plan :

Sensitize the community. Involve health functionaries and village health workers (Government and NGO), schoolteachers, women PRI representatives and women SHGs. Utilize IEC materials. Introduce a parallel record keeping system for ANC, INC, and PNC, and organize refresher training of caregivers.

Nutritional Anemia in Married Tribal Women in Reproductive Age Group

by

Dr. Vijaya Brahme, Sali Medical Foundation (SMF)

Background :

Iron deficiency is the most widespread form of malnutrition in the world affecting more than two billion people (Stolzfus and Dreyfuss, 1998). Nutritional anaemia is estimated to affect nearly two-thirds of pregnant and one-half of non-pregnant women in developing countries. In India, anaemia affects an estimated 50 percent of the population (Seshadri, 1998) due to inadequate intake, poor bio-availability of dietary iron or excessive losses of iron from the body. NFHS-II, 1998, indicated that 49 percent women had anaemia, 32 percent women were mildly anaemic, 14 percent moderately, and 3 percent severely anaemic. The prevalence of anaemia was highest among scheduled tribe women (64 %).

Objectives :

1. to determine the prevalence of nutritional anemia in married tribal women of reproductive age in the study area.
2. to study factors associated with nutritional anemia in the target population.
3. to design an action program to reduce nutritional anemia in tribal married women of reproductive age.

Methodology :

Four villages were selected randomly from Taleghar PHC area. A list of eligible couples was obtained from the PHC. Every fourth woman was selected from the list using the systematic sampling technique with a random start. A pre-tested interview schedule was canvassed to collect data from 136 sampled women in the age group 15 to 45 years. Blood samples were collected and tested for Haemoglobin.

Major Findings :

Out of the total married women only 2.9 percent were 15-19 years, 26.5 percent were 20-24 years, 31.6 percent were 25-29 years and the remaining over 30 years of age. Most tribal married women were suffering from moderate (44.9 %) or mild anaemia (42.6 %). Most women had a body mass index below normal level (below 18.5 kg /m^2) indicating a high prevalence of nutritional deficiency. Women suffering from nutritional

deficiency had a higher prevalence of severe or moderate anaemia. There was no significant associatio between anaemia and family type, economic status, age at marriage, parity, abortion, history of malari and menstrual history. The study indicated that the dietary intake of women is deficient in calories, protein and iron rich foods. Besides tribal women have to work very hard because of which they lose more energy Of the 136 women, 14 were pregnant; all were taking Iron Folic Acid tablets but were still anaemic.

Conclusion :

The food habit and heavy workload of tribal women are the main causes of nutritional deficiency followe by nutritional anaemia.

Action Plan:

SMF proposes to provide food and iron supplements to pregnant women, organise mobile clinics an family planning awareness programs for tribal women and give iron injections, as a single dose, to severel anaemic patients.

Prevalence of Reproductive Tract Infections and Associated Factors in Married Women (15 to 49 yrs)

by

Dr. Abdul Jabbar Sheikh, Nagrik Arojya Rakshaka Sanstha

Background :

Community based studies in India indicate high prevalence rates of RTIs in women. In a study conducted among women in villages of Maharashtra the prevalence of clinically diagnosed RTI was 46 percent. In India these studies have been instrumental in placing the neglected issue of RTIs on the national agenda (Measham and Heaver, 1996)

Objectives :

1. to identify prevalence of reproductive tract infections (RTIs) in married women 15 to 49 years in a rural area.
2. to identify factors associated with reproductive tract infections (RTIs) in married women 15 to 49 years.
3. to plan an action programme based on the research findings to deal with the RTI problems of women

Methodology :

The study, conducted in Amgaon village of Gadchiroli district, covered married women in the age group of 15 to 49 years. A list of women in the study villages was prepared, and 120 women were selected for the study using simple random sampling. Adopting the WHO syndromic approach, information was collected through trained investigators from women using a pre-tested interview schedule, in the local language. The data was analyzed using SPSS software.

Major Findings :

The study indicated that 19.2 percent women were suffering from RTIs. A majority had white discharge (87.0 %), followed by women suffering from yellow discharge (8.7 %). About half the respondents were suffering from these symptoms for 6 to 10 months. One-third women had foul smelling discharge. Over 50 percent women were suffering from abdominal pain or backache or both. Only a small proportion of women had other RTI symptoms. Lower abdomen pain was experienced by 13.3 percent women, followed by other symptoms like itching (10 %) lower back pain (8 %), burning during urination (7.5 %) and pain during urination (4.0 %). There was a significant association between tubectomy and RTIs. The other significant factor related to RTI was fever after delivery.

Conclusions :

A substantial proportion of women reported symptoms of severe RTI, of long duration. RTI in women was significantly associated with female sterilization and delivery, indicating that both these procedures are carried out in unsanitary conditions.

Action Plan :

Nagarik will continue to provide diagnostic services for RTI related health problems. It will train dais to conduct deliveries in a hygienic environment. Women's committees and self-help groups will be involved in this programme and they will be motivated to educate village women regarding prevention of RTIs.

Prevalence of Reproductive Tract Infection and Associated Factors in Married Women (15 To 49 Years)

by

Mr. Nitin Pawar, Rashikashraya Sanskrutik Kala & Bahuuddeshiya Sanstha

Background :

India has had a national programme for the prevention and control of sexually transmitted infections (STIs since 1960s, but services are either poor quality, inaccessible, or socially unacceptable (Luther et al, 1992 Nag 1996; Ramasubban, 1996). Services directed at women, such as maternal care services, have poo coverage, and have until recently, been preoccupied with meeting contraceptive targets. (Gittelsohm et a 1994). Community based prevalence studies of women's health that have been conducted in India indicat that prevalence rate of reproductive tract infections (RTIs) is high. For example in a study conducte among women in two villages in Maharashtra, the prevalence of clinically diagnosed RTI's was 46 percen

Objectives :

1. to assess the prevalence of RTIs in married women in the age group of 15 to 49 years in one village o Yavatmal district.
2. to study factors associated with RTIs.
3. to plan a program based on the research findings.

Methodology :

Women in the age group15 to 45 years were listed and 120 women were selected using the simple randon method. A pre-tested interview schedule was used to collect data on RTIs using the WHO syndromi approach. Data was analysed with SPSS.

Major Findings :

Most of the women were working on their own farms or as agricultural labourers. Majority (72 %) belonge to the lower socioeconomic group. About 31 percent women were suffering from RTI. Of these the majorit (60 %) had only white discharge followed by 30 percent suffering from yellow discharge and about one thir said the discharge was foul smelling. Most women (82 %) complained of lower back pain. Younger, illiterate women had a higher prevalence of RTIs than older, literate women. Excessive bleeding and fever afte delivery were significantly associated with RTIs. Other major factors include tubectomy, abortion and the genital problems in the husband.

Conclusions :

About one third of the women reported symptoms of RTI. The factors associated with RTIs indicate tha they are mostly amenable to preventive interventions. The association with sterilization and abortion need to be urgently researched further.

Action Plan :

Rasikashraya will provide diagnostic and treatment services for RTIs. It will introduce preventive interventions such as safe motherhood and BCC.

Prevalence of Gynaecological Disorders Among Adivasi (Tribal) Women

by

Sailendra Narayan Das, Society for People's Awareness and Rural Development Action (SPARDA)

Background:

Several studies have shown that many Indian women suffer from RTIs. (Bang et al, 1989; Bang, 1991. Pachauri and Gittlesohn 1994). NFHS-II 1998-99, indicates that overall, 23 percent of women either report symptoms of vaginal discharge or urinary tract infection, 11 percent have severe lower abdominal pain and 10 percent have vaginal itching or irritation. Gynaecological problems are equally prevalent among currently married and ever married women.

Objectives:

1. to determine the prevalence of white discharge and uterine prolapse among adivasi women.
2. to find out the factors associated with gynaecological problems in women.
3. to develop an intervention programme based on the study findings.

Methodology:

The study was conducted in 9 villages of Patihinja in Mayurbhanj district of Orissa. Adivasi women in the age group 15 to 45 years were listed and 125 women were selected using the simple random method. A pre-tested interview schedule was used to collect data, which was analyzed using SPSS software.

Major Findings:

Most women belonged to two age groups, 21-30 years (54.4 %), and 31-40 years (37.6 %). Most of the women in the sample were illiterate (83 %). Most women were delivered at home (85 %) and were attended by trained or untrained dais and household members. Nearly half the women got married before the age of 18 years. Two-third of the sampled women suffered from one or more reproductive health problems. White discharge and lower abdominal pain with discharge were the predominant reproductive health problems. Prevalence of reproductive health problems is highest among the Kolha women and least prevalent among Bhumijo tribal women. Interestingly most Kolha women use pads, whereas none of the Bhumijo women

use pads during the menstruation. A large majority of the women suffering from reproductive health problems seek treatment from traditional healers or resort to home remedies.

Conclusion :

A large proportion of tribal women were suffering from symptoms indicative of RTIs, which appear to be associated with behaviours related to INC and menstruation. The health seeking behaviour for RTIs is a cause for concern.

Action Plan :

SPARDA proposes to create awareness about reproductive health among adivasi women. Women's groups will be formed and they will be trained to provide health education, especially to Kolha adivasi women. The organization will liaise with government health facilities to provide RH services.

Male Involvement in Maternal Health Care

by

Jagannadha Sahu, Social Education and Reconstruction of Village Environment (SERVE)

Background :

Several studies indicate gender differentials and an unfavourable environment towards women health issues. (Gender and Reproductive Health Research Initiative: Mapping a decade of Reproductive Health Research in India, 1990-2000). NFHS–II 1998-99 estimates that more than 130,000 women in India die every year from causes related to pregnancy and child-birth. The RCH programme, which was initiated in 1996, seeks to integrate maternal health, child health and fertility regulation interventions with reproductive health programmes for both women and men. (Ministry of Health and Family Welfare, 1997, 1998). There is need to involve men to reduce the burden of work on women as well and to create gender equity.

Objectives:

1. to study the practices of SC and ST male members in maternity health care, and
2. to make an appropriate action plan for increasing male involvement in maternity health care

Methodology :

The study was conducted in 2 Gram Panchayats of Kashinagar Block, Gajapati District of Orissa. The target population of men with a child less than one year of age was enumerated. A simple random sample of 100 men was selected. Data was collected through a pre-tested interview schedule and analyzed using SPSS software.

Major Findings :

Half the respondents were above 35 years and a third were in the age group 25 to 35 years. Most respondents were illiterate. Majority belonged to scheduled tribes (82 %), the remaining to scheduled caste. Majority was economically backward. Only half the women were registered for antenatal care. Of those registered for ANC, 37 percent women were accompanied by their spouses for ANC registration. Most accompanied their wives twice or thrice for antenatal care. Younger men accompanied their wives more than older men. Majority of husbands of scheduled tribe women did not provide nutritious food to their pregnant wives, but a large proportion of scheduled caste men provided extra food to their wives. Only a small minority of husbands accompanied their wives for postnatal care. Men prefer their spouses to deliver at home. They prefer that their wives adopt family planning methods, rather than themselves.

Conclusion :

Male participation in the maternal health of women is poor. It is better in men belonging to scheduled castes as compared to men belonging to scheduled tribes.

Action Plan :

SERVE shall generate awareness regarding the reproductive health needs of women and the importance of male participation. It will increase male participation in women and child's health.

Comparison Of The Levels Of Knowledge And Attitude Towards Select Health Issues Of Illiterate Women Who Have Undergone Literacy Program With Those Who Have Not

by

Vinita Chacko, Tushar Community Health Education and Development Project

Background :

Health literacy can only be achieved through a process of health education, which seeks to develop understanding of health issues and how to apply these to make decisions. This challenge was taken up by the Tushar project, which incorporated certain health messages into its ongoing adult literacy program for women of 15-35 years of age.

Objectives:

The objectives of the study include

(1) comparing the level of knowledge regarding select health issues of women having undergone the literacy program and those who have not,

(2) comparing the attitude of women having undergone the literacy program and those who have not to select health issues,

(3) finding out the association, if any between select characteristics of the respondents and their levels of knowledge / attitude to select health issues and

(4) deriving an appropriate action plan, on the basis of the findings of the above objectives to improve the training programmes.

Methodology :

The study was undertaken in Manduwala, Dehradun district, Uttranchal. Two out of the seven villages in which the project has been working were selected by simple random sampling from the list of villages. In the two sample villages all the 100 women 15-35 years who had been trained and were available were interviewed. In the same 2 villages, another 100 illiterate women who had never undergone training were selected from a list of all such women of the age group 15-35 years. A pre-tested structured interview schedule was canvassed with the respondents.

Major Findings :

All the 100 trained and 97 percent of the untrained women emphasized the need for antenatal care. But the trained women could perceive the need for antenatal care better. While 34 percent of the trained ones perceived that antenatal care was needed for safe delivery, only 20 percent of the untrained perceived so. Similarly, 80 percent of the trained ones felt that antenatal care was needed for healthy baby; such a perception was found among only 30 percent of the untrained women. Among the trained women, 89 percent were aware that TT injection prevented tetanus but only 54 percent of the untrained women were aware of this. In case of illnesses, larger proportion of untrained women than the trained ones, were likely to go to quacks. An overall score was given to each of the respondents depending on the correct responses given by them both for correct knowledge and positive attitudes. There was statistically significant difference in scores of the trained and untrained responses both in their knowledge and attitudes.

Conclusion

The study reveals that incorporating health education with a normal adult literacy program (using primers devised by the National Literacy Mission) has had an impact in changing knowledge and attitudes of women towards certain health behaviours.

Action Plan :

(1) to repeat the study in other EHA projects.

(2) incorporate health education messages in all ongoing literacy programs in EHA.

(3) improving the existing government literacy program by incorporating health messages in it and preparing a manual of the same.

OVERVIEW

A substantial proportion of women reported symptoms of severe RTI, of long duration. RTI in women was significantly associated with female sterilization and delivery, indicating that both these procedures are carried out in unhygienic conditions and need to be researched.

The factors associated with RTIs are mostly amenable to preventive interventions.

The health seeking behaviour for RTIs is a cause for concern.

The utilization of ANC and PNC services in these villages is low. Most pregnant women are delivered by their husbands or untrained TBAs. Lack of awareness, illiteracy and inaccessibility of maternal services are associated with this problem, which planners need to take into account during future planning of RCH services.

From a preventive and promotional perspective incorporating health education with a normal adult literacy program (using primers devised by the National Literacy Mission) has had an impact in changing knowledge and attitudes of women towards certain health behaviours.

IV : COMMUNICABLE DISEASES

Part 1 : HIV/AIDS

1. Needs Of Women Carers Of Those Affected By HIV/AIDS
   Bindiya Nimla, Madhavi Shinde, CCDT

2. Health And Socio-Economic Problems Of Spouses Of Persons Infected With HIV/AIDS
   Upendra Singh, SHALOM

3. Behaviors And Factors Associated With Risk Of HIV Infections Among Migratory Workers
   Donald William, Health and Hope Project

Part 2 : Other Communicable Diseases :Leprosy, Malaria, Tuberculosis and Water-borne Diseases)

4. Knowledge About Leprosy Among Private Medical Practitioners
   Meera Lad, Kushtarog Nivaran Samiti

5. Perceptions Of General Hospital Staff Towards Leprosy Affected Patients
   Vinod Kumar, Leprosy Mission

6. Indigenous System Of Treatment Of Malaria
   Dillip Kumar Nanda, SAHAYA

7. Tuberculosis Control Programme Of Ramakrishna Mission Ashram:
   An Evaluation Study
   Swami Janakishananda, Vivekananda Arogya Dham

8. Waterborne Diseases In Riverbank Villages: A Comparative Study
   Sunil Deshmukh, Yuvagram

OVERVIEW

COMMUNICABLE DISEASES: KNOWLEDGE, ATTITUDE AND HEALTH SEEKING BEHAVIOUR

Introduction :

The most common communicable diseases are HIV/AIDS, Leprosy, Malaria, Tuberculosis, and water borne diseases. Each of these has been briefly discussed separately in the following sequence:

I : HIV/AIDS.

II : OTHER COMMUNICABLE DISEASES

A. Leprosy

B. Malaria

C. Tuberculosis

D. Water borne diseases.

I. HIV / AIDS :

It is estimated that there are 3.5 million HIV infected cases in India. However there is no clear indication about the number of AIDS cases. There are speculation that the incidence and prevalence of AIDS is likely to increase in the coming years. In India the main risk behaviour that causes HIV infection is through different kinds of sexual behaviours such as pre-marital sex, extra-marital sex and homosexuality. However there are other risk behaviours such as sharing of needles for drug infusion and blood transfusion, which do contribute for HIV infection. The focus of the present study is on the sexual behaviour of the general population that leads to HIV infection. In this connection there are not many studies on the sexual behaviour of general population leading to HIV infection. More specifically it is a common observation that such behaviour is predominant among migratory workers and those, whose work is mobile in nature, for example, truck and bus drivers and related staff. Therefore it is important to understand the sexual behaviour in terms of their knowledge and attitude to sexually transmitted diseases and their high risk behaviour.

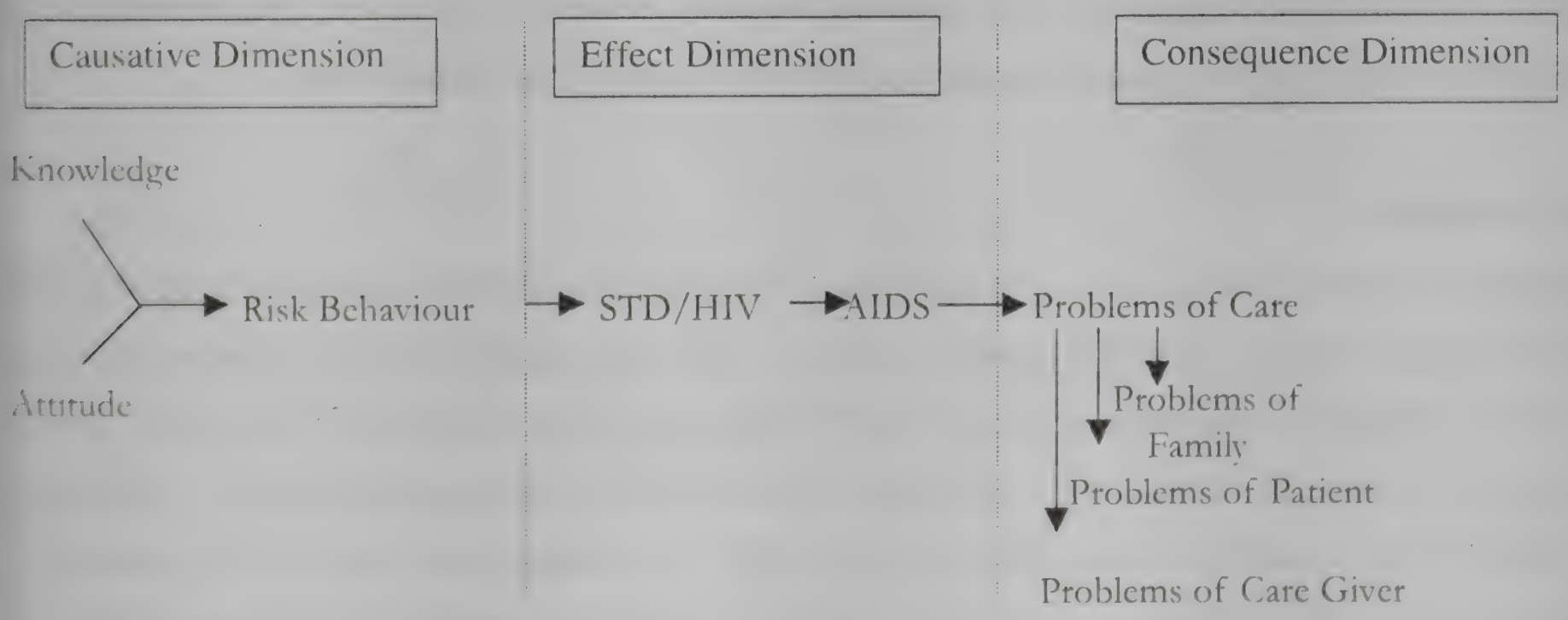
While mostly men through their high risk behaviour contract HIV infection, their wives and children become secondary victims of the infection. It is believed that this secondary infection is spreading fast in India that will contribute for high prevalence of HIV / AIDS in the country.

One of the major consequence of the high risk sexual behaviour is STD which has close links with HIV / AIDS. Studies in Africa show that control of STD has led to reduction in the HIV infection. Therefore the cycle of AIDS is so complex, it starts with high-risk sexual behaviour, leading to STD to HIV infection, ultimately the patient succumbing to AIDS. Given the scenario, it is important the family at risk need to be understood in the context of high risk behaviour of the male member in the family. On the one hand the problems created for the members of the family, particularly the spouse and children leading quite often to their own acquiring of the disease and on the other hand, the family members being called upon to be the care-givers. These are two aspects which have been hardly explored within the phenomenon of HIV / AIDS.

Therefore the present study focuses on high risk sexual behaviour leading to STD and HIV / AIDS resulting in affecting the family members (wife and children) who in turn have to look after the AIDS patient in the family. In the absence of any significant institutional care and treatment for the patient, the family becomes the exclusive carer of the AIDS patient. Though the Indian family system is still strong, but it has several limitations in terms of financial burden and social stigma to take care of the AIDS patient. So in this context, it is important to understand the perception of the AIDS patient towards care giving in the family (home-based care) as well as to understand the problems faced by the family members who are care-givers.

The proposed study is best reflected in the three dimensional framework presented below.

Conceptual Framework :



Abstracts of the three studies that have been done on this disease is presented below.

Needs Of Women Carers Of Those Affected By HIV/AIDS

by

Bindiya Nimla, Madhavi Shinde, Committed

Community Development Trust (CCDT)

Background :

Women are increasingly carrying the burden of caring for those affected by HIV/AIDS. However in th literature available on HIV/AIDS, the role of women carers – and more pointedly, their needs – receives onl cursory mention. Hence it was decided to undertake this study to fill in the gap in knowledge.

Objectives :

(1) to ascertain the characteristics of women carers.

(2) to explore the problems faced by women carers in giving care.

(3) to understand the mechanisms for coping with problems among women carers and

(4) to identify the gaps in the support systems available for women carers and the strategies to deal wit the gaps.

Methodology:

All 60 women carers from 193 families of CCDT's project CHILD (Children of HIV positive Individuals Livin in Dignity) at Mumbai and Thane, were covered under the study. However, only 53 were interviewed utilizin an interview schedule as the remaining seven could not be traced or had passed away.

Major Findings :

Seventy three percent of carers were in the age group of 19-37 years. Less than 20 percent had studied t higher secondary and were domestic servants. The main difficulties faced by the carers were in terms o Opportunistic infections, Planning and preparing for future, Acceptance of persons serostatus, lack o family/friends support, lack of money for quality food, absence of care and support systems. Compared t men, women were disproportionately affected by HIV/AIDS. As mothers, they were at risk to transmit (HIV/AIDS) to their children. Women were often carers for partners / children / family members and eve neighbors who were sick. To add to the unequal gender (social, economic and power) relations also affecte the increase in spread of the infection.

Conclusion:

The women with HIV/AIDS have multiple needs when there are children and other family members to be taken care of. Often they find it difficult to go to work thus increasing the need for finance, childcare and household support. Women's role is often restricted to look after the family routines and children, preparing meals and serving in bed. And when the spouse expires or there is lack of family support, the women have to seek employment. Economic improvement is a high priority for women carers. The need for continuous psychosocial support and continuity of care at all levels are clearly relevant. It is necessary consciously to identify the needs of each family and provide the financial help and emotional support they require to cope with HIV/AIDS in the family.

Action Plan :

Programmes are planned on Vocational guidance and employment generation to women carers, Life skills education; and Counseling and Social support.

Health And Socio-Economic Problems Of Spouses Of Persons Infected With HIV/AIDS

by

Upendra Singh, Society For HIV/AIDS Life Line Operation (SHALOM)

Background :

India is expected to have the largest concentration of "People living with HIV/AIDS" (PLWHAs) in the world if the current rate of transmission continues. The epidemic coupled with stigma and discrimination has devastating effect on the family members of the infected.

Objectives :

(1) to find out their morbidity pattern.

(2) to ascertain their perceptions regarding stigmatization, discrimination and deprivation resulting from their husbands having become HIV/AIDS patients,

(3) to use the findings of the study to develop a programme to provide services to spouses and children of persons infected with HIV/AIDS.

Methodology :

From a list of 400 women whose husband was infected by HIV, a systematic random sampling was adopted to select a sample of 100 women. The data were collected using a pre-tested interview schedule in Churachandpur, Manipur.

Major Findings :

An extremely high 88 percent reported that they were ill at the time of interview, and 94 percent feared that they had already contracted HIV. Again a high 89 percent were found to be unemployed. 96 percent said that they were ashamed, angry and sad when they knew about their husband's HIV status. 59 percent of the women managed to keep their spouses' HIV status a secret for more than a year.

Conclusions :

The study shows that spouses and children of HIV/AIDS are vulnerable to different illness. The women also feel ashamed, fear to share their husband's status with others. More than half of them were daily wage earners. Most of the children are staying with their mother and only half of them are attending school.

Action Plan :

A project to support these women and children in terms of health, nutrition and children education will be implemented. Home-based care services and opportunistic-infection treatment as well as individual and family counseling will be provided. IEC programme will be planned to decrease stigmatization and discrimination.

Behaviors And Factors Associated With Risk Of HIV Infections Among Migratory Workers

by

Donald William, Health and Hope Project

Background :

Expanding at an accelerated rate in every country, there are 16,000 new HIV infections daily in India. Approximately 6 million new infections were noticed in 1998 alone and at the end of the year 33.4 million people were living with HIV. Estimated 25 percent of infections are currently among women. Approximately 30,000 newborn children are infected, and the country may have 1,20,000 AIDS orphans. 75 percent of infections are through sexual transmissions, 8 percent through IV drug use and 8 percent through blood transfusion etc. Migration of population is an important key factor in the spread of HIV in India. Over 180 million are migrant workers in India many of whom are single men. The migrant men account for much of the clientele of the 'red light' areas. In a study of 5,722 male truck drivers in Assam, 82 percent of men reported regular sex with CSWs without use of condoms. 15 percent reported a history of sex with men, 40 percent used cannabis and 24 percent had injected heroin.

In Maharashtra the prevalence climbs to 1.14 percent, close to twice the national average. In June 2001, Health and Hope Project conducted knowledge practice survey in 6 villages and 918 respondents were quizzed about their knowledge of HIV/ AIDS and its prevention. Just about half of them or much less than that proportion had heard about AIDS, sexual mode of transmission , transmission through injectable route, and none of prenatal transmission. Use of condom was very minimal.

Area hospital records on the prevalence of HIV positive cases presenting at our hospital from 16 target villages covering a total population of 2500 revealed 50 cases and out of them 35 were from migratory background.

In this context a study on high risk behaviour through HIV infection was considered necessary to develop appropriate health awareness programmes in the area.

Objectives:

(1) to determine migratory workers' exposure to risk behaviour resulting in HIV infections.

(2) to determine the factors associated with risk behaviour

(3) to plan an appropriate IEC programme on health awareness for migratory workers.

Methodology :

A total of 10 villages of Taluka Ausa at district Latur with an estimated population of 15,000 formed th study population, and 16 migratory workers were selected by simple random sampling method from eac of the 10 villages.

Major Findings :

Older migrants stayed for longer duration in places of emigration (P = .026). More young migrants were manual labourers compared to older migrants (P = .022). More educated migrants were longer duratio migrants compared to low educated group. (P = .054). Illiterates and poorly educated migrated alone an majority of them were manual labourers. 41 percent had multiple sex partners.

83.1 percent migrate alone. 72.5 percent do the manual labour only 27.5 percent do other jobs like drive helper, clerk etc. Mostly these workers prefer the Heterosexual relationship because only 8.1 percen workers are involved in Homosexual. 40.6 percent have multisex partner and 26.9 have contact with CSWs

When we asked about the number of sex contacts then we found 71.3 percent had contacts with CSW more than 2 times. Only 20 percent are illiterate, 9.4 percent are educated and others have low level o education.

Very high percentage of not using condoms that is 80 percent; use of Alcohol approximately equal in both cooes, that is 50.6 percent yes and 49.4 percent said no.

Association of select variables like Age, Marital status, Caste, were analyzed and shown as cross tables. Religion and Education with risk factors and behaviour to HIV infection

Conclusions :

Lack of literacy results in availability of menial jobs that in turn result in low social standing. Study shows that Age and Education affect duration and type of work.

Action Plan :

Adult literacy programme for adults will be conducted. Dissemination of information for HIV/AIDS/STD to individuals through out-reach educators. Counseling services will be provided. Use wide range of media to promote knowledge about AIDS/HIV/STD.

II OTHER COMMUNICABLE DISEASES

A. LEPROSY

Leprosy is on the decline and we may be able to eliminate it in this decade. However, the post-infective phase of leprosy is still a problem not only for the society, but also for the healthcare providers of former leprosy patients. Due to the deformity the ex-leprosy patient is labeled as a leprosy patient all through his life. Even healthcare providers, both public and private sector, tend to reject and discriminate against them when they seek treatment for general illnesses.

As per the recent assessment, incidence of leprosy has declined sharply. The prevalence rate of leprosy has come down to 5 per 10,000 population because of intensive multi-drug therapy. At this stage the government is also planning to integrate the vertical programme of leprosy with the government general health programme. However, stigma related to leprosy patients, including cured patients, persists not only in the society at large, but also among the healthcare providers. If we want to integrate the leprosy programme with the general healthcare programme, the healthcare provider must have positive attitude towards leprosy-infected patients as well as cured patients who have deformities. The present study focuses on the knowledge and attitude of providers towards Leprosy patients, including cured patients.

B. MALARIA

While malaria was almost brought under control in the seventies it has re-emerged with a vengeance in the nineties and in the present decade.

Malaria is a re-emerging disease in the country, which was almost under control in the seventies. Its incidence started increasing since then and reached to the extent of 2.202 million cases in 1989. The problem further got complicated with the increasing incidence of falciparum malaria, which contributed for high mortality. The disease is wide-spread in low income areas like tribal areas, urban slums and poor rural areas. Due to lack of vector control programme and also due to non-availability of drugs to treat malaria, the disease has spread all over the country. It has adversely affected the poorer sections of the society. When the disease affects them they tend to go to different types of healthcare practitioners to deal with the problem. They not only try out various allopathic medicines, but also medicines from other systems, especially in tribal areas. To develop an effective strategy to deal with malaria problem among the poorer population, it is necessary to understand their treatment seeking behaviour and utilization pattern of health services for malaria. The present study concentrates on these aspects.

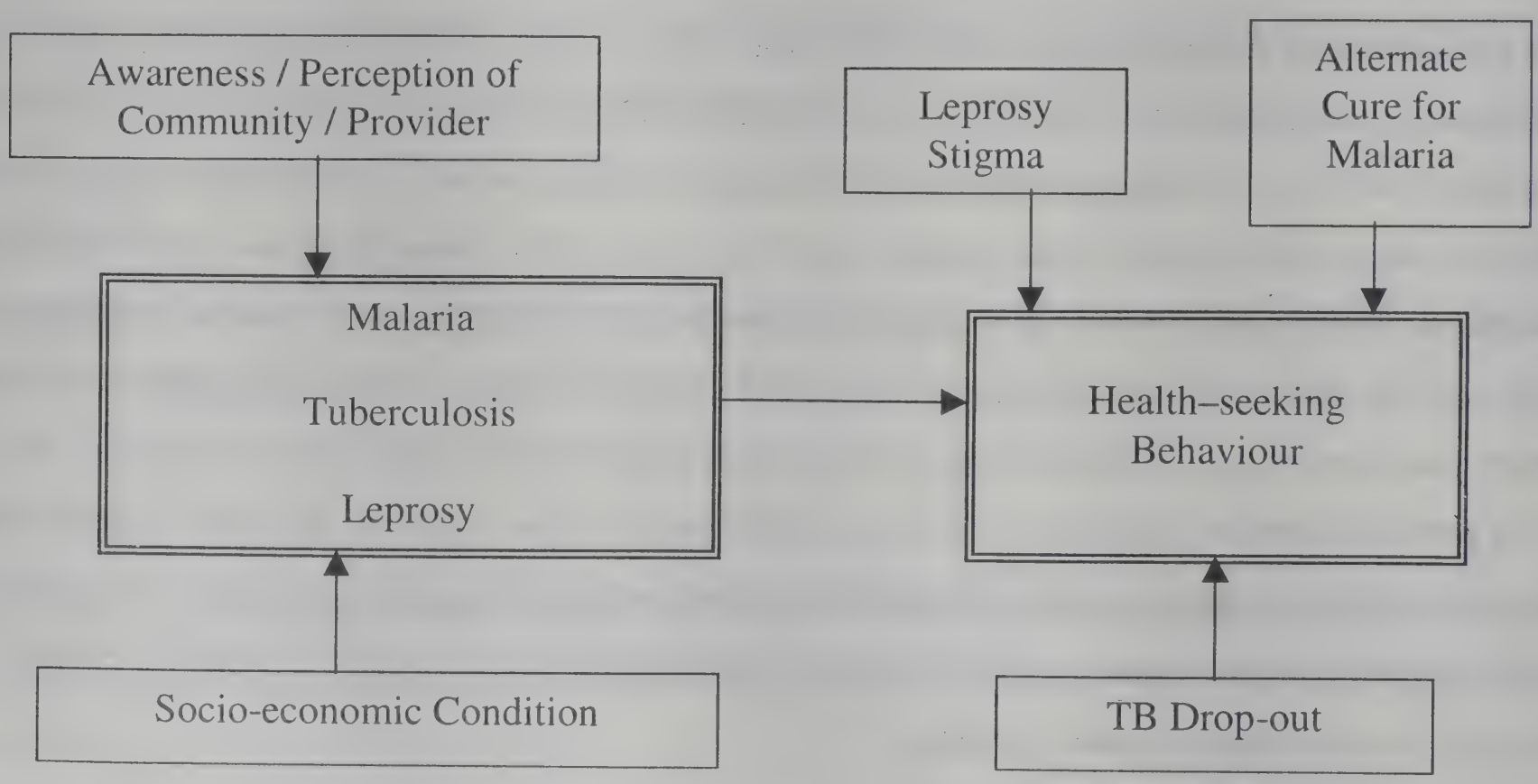
C .TUBERCULOSIS

In India every second adult person is infected with TB bacterium. Every year more than 2 million peopl develop active tuberculosis and 5 lakh people die (WHO Report on the Tuberculosis Epidemic 1997). The incidence and prevalence of tuberculosis is on the increase and the problem is further complicated with the increasing prevalence of AIDS. Though India has introduced DOTS strategy to deal with the problem of TB in certain parts of the country, it has shown varied results. The problem of treating TB is a complex process It has been observed that the health seeking behaviour of TB patient is often quite complex and the government has a tremendous challenge to deal with the long-term treatment. Often the patient reaches the government treatment center very late. Before coming to the government treatment center he goes through a long list of other providers including quacks and private practitioners. By the time he reaches the government treatment center, he is drained economically and physically. Further, after starting the treatmen in the government treatment center, he drops out in the middle once he is relieved of the symptoms of TB though not cured. This is a major challenge for the government health worker to ensure compliance of ful treatment. The present study envisages covering all these complex issues of tuberculosis treatment to throw light on adopting a more effective strategy to deal with the problem of Tuberculosis.

D. WATERBORNE DISEASES

The above-mentioned paragraphs brought out the complex issues of the major communicable diseases Though they are different and distinct diseases they collectively affect the poor to a great extent. Therefore the present study deals with them together.

Conceptual Framework :



Keeping the above in perspective, seminal studies were done on communicable diseases in different parts of India. The abstracts of these studies are now presented below in the following sequence:

A. Leprosy

B. Malaria

C. Tuberculosis

D. Water borne diseases

Knowledge About Leprosy Among Private Medical Practitioners

by

Meera Lad, Kushtarog Nivaran Samiti

Background :

In Maharashtra about 40 percent of leprosy patients seek treatment from Private Medical Practitioners (PMPs). For eradication of leprosy it is essential that the providers of leprosy treatment have proper knowledge about leprosy.

Objectives :

(1) to assess the level of knowledge among the private medical practitioners (PMPs) on leprosy detection and prevention of deformity.

(2) to find out the characteristics associated with high and low levels of knowledge among the PMPs.

(3) to prepare an action plan for increasing the knowledge related to leprosy among PMPs.

Methodology :

This study was undertaken in Panvel taluka, Raigad district, Maharashtra. From a list of 331 registered PMPs, a stratified systematic sampling scheme was adopted to select the respondents. A total of 162 respondents consisted of 59 from allopathic, 69 from ayurvedic / homoeopathic and the remaining 34 from other systems of medicine. A pre-tested interview schedule was canvassed with the respondents.

Major Findings :

While 84 percent of PMPs had correct knowledge about clinical characteristics, only 55 percent had correct knowledge about signs of advanced leprosy. Nearly half the respondents (48.8%) knew about the special footwear to be used by patients of Leprosy. Also a minority of 37 percent knew about the care of hands by patients. In general the practitioners of Modern medicine (76.3%) had a better knowledge compared to other systems of medicine (23.7).

Conclusion:

There is an urgent need to reorient Private Practitioners in Panvel Taluka, on the management of Leprosy Patients.

Action Plan :

The Organization will arrange for orientation of the Private Practitioners in the management of Leprosy. The curriculum of the orientation will be designed along with the State Leprosy Control Bureau.

Perceptions Of General Hospital Staff Towards Leprosy Affected Patients

by

Mr. Vinod Kumar, The Leprosy Mission

Background :

Leprosy patients find it difficult to receive treatment for non-leprosy health problems from government hospital due to negative attitudes of hospital staff and very often treatment is denied to them. Hence this study was undertaken to find out the present situation in the project area.

Objectives :

(1) to ascertain the perception of the general hospital staff about identifying leprosy and their views on select aspects regarding treatment of leprosy affected patients in the general hospital.

(2) to create an appropriate atmosphere, health education to change attitude/behavior towards leprosy patients.

Methodology :

A pre-tested interview schedule was canvassed with a sample of 100 out of the 750 employees of all categories in the hospital to ascertain their knowledge on various aspects of leprosy, like signs and symptoms of leprosy, infectivity, curability, cause of deformity and attitude on problems encountered in treatment of leprosy patients in a general hospital.

Major Findings :

While a vast majority of 89 of the 100 respondents could identify patches as identifiable sign of leprosy, only a minority of them could identify the other common and visible signs like disability and deformity that are invisible in advanced cases of leprosy. One in every four of the respondents was not in favor of encouraging admission of leprosy patients into the hospital. Of the majority who favoured the treatment of leprosy patients, some staff felt that there could be some problem to admit them as in-patients due to social stigma of general patients, improper facilities available to treat such patients especially those who may be infectious.

Conclusion

General hospital staff had basic knowledge about leprosy and was generally in favour of treating leprosy patient in general hospitals.

Action Plan

Training programme will be conducted for various categories of hospital staff to improve their awareness about leprosy and to improve their attitude towards the leprosy patients.

Indigenous System Of Treatment Of Malaria

by

Dillip Kumar Nanda, Service Activities For Human Affairs With Youth Action (SAHAYA)

Background :

Malaria is a curable and preventable disease but it still kills many people. In the absence of modern healt care facilities and medicines in rural areas, people resort to locally available "medicines" or approac indigenous healers to treat malaria. The NGO decided to explore this phenomenon.

Objectives :

(1) to find out different indigenous treatment of malaria.

(2) to study the utilization pattern of indigenous treatment of malaria.

(3) based on the findings of the above-mentioned objectives, to prepare an action plan to deal with th problem of malaria in the target population.

Methodology:

Data were collected using interview schedules from 78 individuals who had malaria during the previou year and from 16 treatment providers in eight villages of Barasahi gram panchayat, Nayagarh district Orissa.

Major Findings :

Most of the households (95%) used ayurvedic medicine (*Gangasiuli* and honey) for treatment of malaria 45 percent reported that 'Good for health' is the main reason for using indigenous medicines. Using mosquito nets, burning mosquito coils/neem leaves, applying neem oil are the major preventive measures adopted for avoiding mosquito bites. According to indigenous providers, 20 percent of people suffer from malaria and among them only 20 percent using indigenous methods and that too mainly for prevention.

Conclusions :

Indigenous medicine for malaria is popular and cheapest and the users are satisfied with it. Indigenous medicine is used for preventing mosquito bites as well.

Action Plan :

Village meetings in 8 villages will be organized to disseminate knowledge on proper usage of mosquito nets, indigenous malaria prevention, prevention of mosquito breeding, water logging management etc.

Tuberculosis Control Programme Of Ramakrishna Mission Ashram : An Evaluation Study

by

Swami Janakishananda, Vivekananda Arogya Dham

Background :

Ramakrishna Mission (RKM) Ashrama started the Tuberculosis (TB) control programme based on DOTS strategy in all villages of Narainpur block. After running the programme for 3 years an evaluation to assess the achievements and to know the factors that contribute to the spread of infection became necessary.

Objectives :

(1) to compare the incidence and prevalence of TB in the community before and after the intervention by the RKM.

(2) to find out the socio-economic factors associated with TB cases in the community.

(3) to assess the level of awareness of TB patients regarding treatment of TB.

(4) in light of the above objectives, to prepare an action plan to improve the TB programme of the RKM.

Methodology :

On a sample of 250 TB patients either currently suffering from TB or have ever suffered from TB, from a list of 730, selected by systematic random sampling, data were collected using an interview schedule, containing information related to socio-economic factors, knowledge and awareness about TB and its treatment.

Major Findings :

A majority of the patients (62.3%) belonged to low socio-economic group. Majority (98.8%) were aware of the requirement of regularity of taking treatment, (91.0%) on actual duration of treatment, (93.4%) on curability of disease and (75.4%) on the requirement of continuation of treatment even if the symptoms of TB disappear.

Conclusions :

Low SES and poor housing conditions, which lead to illiteracy and ill health predisposed to TB, may cause the occurrence of new cases of TB in the community. Majority of the patients have good awareness / knowledge about the disease.

Action Plan :

Undertake socio-economic programmes to improve the living conditions of the community. Programmes to raise the economic status as well as to change social practices that are harmful to healthy living.

Waterborne Diseases In Riverbank Villages: A Comparative Study

by

Sunil Deshmukh, Yuvagram Vikas Mandal

Background :

During the last decade i.e. 1990 to 2000, experience relating to water and sanitation proved that improvement in drinking water alone is not sufficient to reduce water borne diseases (Ref. Global water supply & sanitation assessment report 2000 - UNICEF). There is a need for change in personal and defecation hygiene behaviour to stop oral-faecal transmission. However sanitation programmes in India only speak of diarrhoeal diseases and their control by ORS/SSS and ignore the sustained latrine use and key hygiene behaviours. So it has become essential to promote rural sanitation to improve the health of Indian villages thereby reducing the rate of waterborne diseases. And hence the need initially got basic reality data.

Objectives :

(1) to study the knowledge and practice levels of villagers regarding water borne diseases, home treatment methods and preventive measures.

(2) in the light of the findings to prepare an action plan to increase the level of hygiene in the community.

Methodology :

A survey using an interview schedule to collect data from heads of households from two groups of villages; one where a World Bank assisted intervention by way of provision of sanitation facilities and hygiene education was undertaken (in 1000 households); and another area that consisted of 924 households where there was no such intervention. A stratified simple random sampling method was followed to select 212 households from WB project areas and 181 households from non-project areas.

Major Findings :

In WB Project Villages 14.6 percent and in Non-Project villages 2.5 percent of households had toilets. Although the number of toilets were more in the WB Project Villages, usage was very poor in both groups of villages. Knowledge about hand washing after defecation was only marginally higher in the WB Project Villages. Knowledge on use of ORS and Sugar Salt Solution was better in the WB project areas. Only 16 People in the WB Project Villages and 9 in the Non Project Villages had fallen sick during the past 3 Months.

Conclusion :

There is no significant difference observed in the levels of knowledge and practice of acceptable hygienic behaviour between the two communities. Hygienic behaviour is very difficult to change, over a short period of time.

Action Plan :

Village Level Committees will be formed to discuss the issue, and motivate people to improve personal hygiene and household sanitation. Through health education programmes, school level hygiene will also be improved.

OVERVIEW:

HIV/AIDs

The vast majority of workers migrate alone leaving behind their families behind. Most workers prefer Heterosexual relationship, may have multi-sex partner and contact with CSWs more than 2 times. They do not use condoms and consumed alcohol. These are collectively high risk behaviours leading to contracting HIV/AIDS.

Spouses and children of HIV/AIDS are vulnerable to different illness. The women also feel ashamed, fear to share their husband's status with others. The spouses have multiple needs including finance, childcare and household support. When the spouse expires or there is lack of family support, the women have to seek employment. Economic improvement, psychosocial support and continuity of care at all levels are clearly relevant.

Leprosy :

There is need to reorient Private Practitioners in Panvel Taluka, on the management of Leprosy Patients. By and large hospital staff have basic knowledge about leprosy and generally in favour of treating leprosy patient in general hospital.

Malaria :

Indigenous medicine for malaria is popular and cheapest and the users are satisfied with it.

Tuberculosis

Low SES and poor housing conditions lead ill health predisposed to TB and may cause the occurrence of new cases of TB in the community. Majority of the patients have good awareness / knowledge about the disease.

Waterborne diseases

There is no significant difference in the levels of knowledge and practice of acceptable hygienic behaviour between the two communities probably because hygienic behaviour is very difficult to change, over a short period of time.

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V : NON-COMMUNICABLE DISEASES

Part A : Tobacco Use

1. Tobacco Consumption Among School Boys
   Mrudula M Kelkar, Friends Puppet Theatre
2. Tobacco Use Among Adolescent Population
   P B Yadav, Prakash Shikshan Prasarak Sanstha,
3. Tobacco Chewing Among College Students And Its Effects On Oral Health
   Munghate Raju Govindrao, Vidyabharti Mahavidyalaya
4. Tobacco Use Among Women In The Reproductive Age Group
   Antaryami, RDSS

OVERVIEW

Part B : Cataract Surgery

1. Factors Determining Acceptance Of Surgical Treatment For Cataract
   Swati A. Dixit, Mohan Thuse Netra Rugnalaya
2. Factors Determining Acceptance Of Cataract Surgery By Women
   Dhirendra Kumar Mohanty, NYSASDRI

OVERVIEW

TOBACCO USE AMONG CHILDREN, YOUTH AND WOMEN : EXTENT, REASONS AND PERCEIVED HEALTH EFFECTS

Introduction

According to the World Health Organization, every year about four million deaths take place due to Tobacco use. Of these, 50 to 70 percent are from the developing countries. Tobacco use is one of the greatest causes of preventable deaths and disease in human history. Given the current trends, by 2020 tobacco is expected to become the leading cause of preventable mortality and morbidity in the world, with approximately 8.4 million deaths annually.

Some of the health problems associated with extensive use of tobacco are cardio vascular diseases, oral cancer, chronic obstructive pulmonary diseases, sub-mucous fibrosis, tooth abrasions, spontaneous abortion and premature birth among women and gum recession. According to Indian Council of Medical Research, nearly 160,000 people develop cancer in India each year as a result of tobacco consumption. Another 4.5 million people with angina or heart disease, and about 3.9 million people with chronic obstructive lung disease have also been affected by smoking.

Smoking is the most common form of tobacco use and 1.1 billion people worldwide smoke. More than 200 million Indians use tobacco daily and one-fifth of the tobacco consumed is in the smokeless form. Four million children below the age of 15 are tobacco users.

In a country like India, there is wide variation in tobacco consumption pattern. There are different forms of smoking tobacco as well as smokeless tobacco. Some of these forms include cigarette, *bidi*, cigar, *hookah, gutkha, khainy, maawa,* and *masheri.*

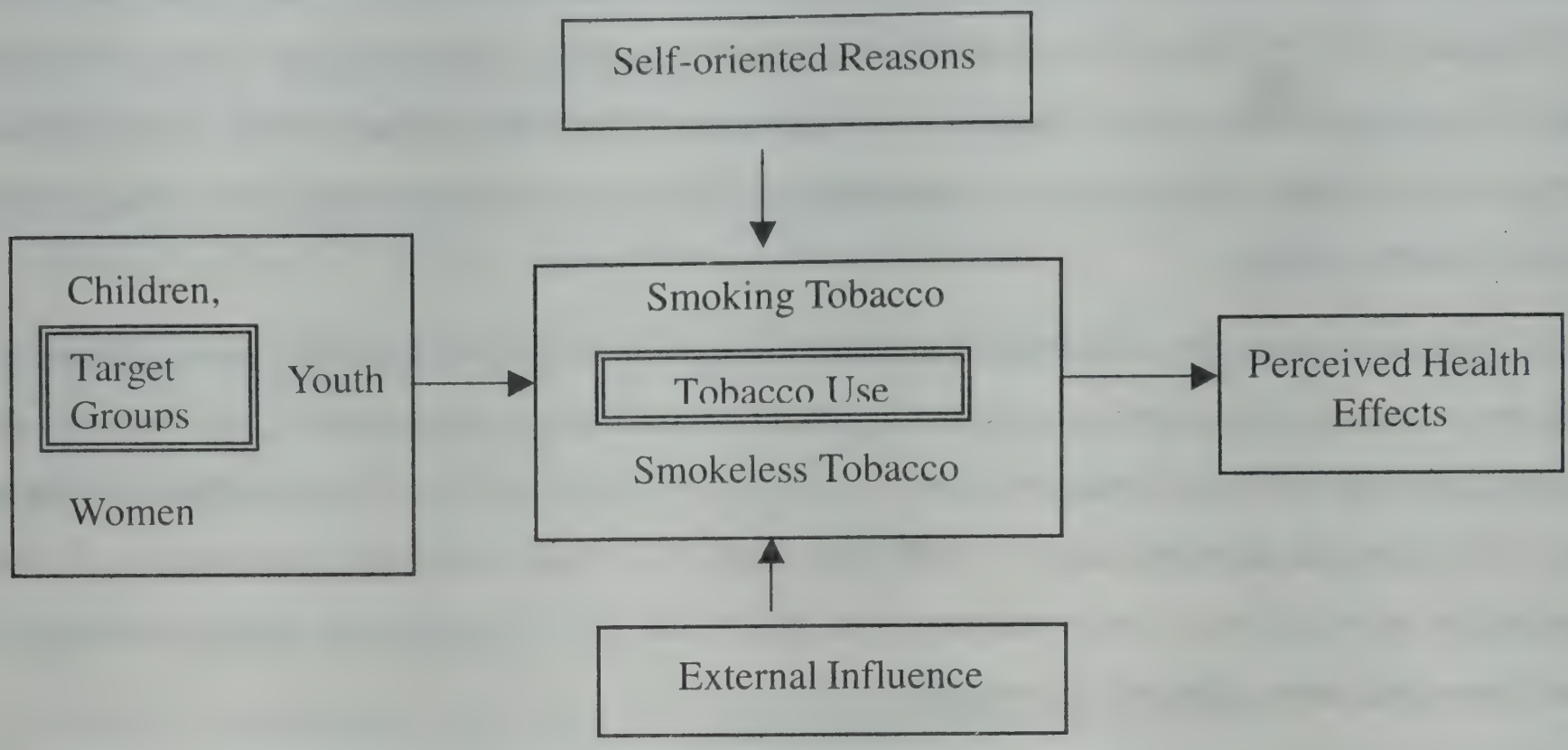
Smoking among children and young people is a distressing phenomenon, not only among the affluent households, but also among the poorer sections of society. Growing evidence shows that children are smoking more and starting to smoke at younger ages. Studies have shown that most tobacco users start using tobacco in their young age. Therefore, it is important to understand the reasons and the tobacco use pattern among the young population to prevent the problem.

Various reasons for tobacco consumption among young population include imitation, curiosity, relieving boredom, act of defiance and so on. Youth are the target of tobacco industry in developing countries. Therefore understanding of the phenomenon of tobacco use among children and youth will help health experts to devise interventions to curb the problem.

Given the need to have authentic information about the various dimensions of tobacco usage before any

meaningful curative, preventive and promotional programmes can be undertaken, it is essential ground level data are collected, collated and analyzed. Thus the thrust of the studies should conform to the following conceptual framework.

Conceptual Framework :



Objectives

Keeping the above in mind, four studies were undertaken to ascertain the use, reason for use and perceived ill-effects of tobacco among children, youth and women in the reproductive age group. The objectives of these studies were

1. to ascertain the extent of use of tobacco in any form in the target populations,
2. to discern the reasons for these persons to consume tobacco in any form,
3. to clarify the form in which tobacco is used, and
4. respondents' perception of the effect of tobacco consumption on their health.

All four, undertaken in urban rural and tribal communities, utilized some variation of a probability sample ranging from the simple random to the clustered and stratified. All four studies had relatively large samples ranging from 175 to 200. Given the target group, the age groups covered varied from age 10 to 45 years. This range should provide important data on generational changes that have taken place.

Also, all four studies resorted to pre-tested and pre-structured tools of data collection, which were initially translated into the local language. Two studies used interview schedule and the other two utilized questionnaires.

The abstracts of the four studies are now presented.

Tobacco Consumption Among School Boys

by

Mrudula M Kelkar, Friends Puppet Theatre

Background :

During puppet shows in Pune Municipal Schools, the NGO found evidence of high tobacco use among school children. Used *bidi* and cigarette butts were strewn in the school campus. This prompted the NGO to undertake this study.

Objectives :

The three objectives of the study were:

1. to find out the proportion of boys using any form of tobacco,
2. to find out various forms of tobacco use among boys, and
3. to study the various reasons for tobacco use.

Methodology :

Using a systematic sampling procedure, 200 boys were selected from one private school in a slum in Pune City. Division 'A' was selected from each of the classes 5 to 8 in the school. A pre-tested questionnaire in local language was used to collect information from the respondents on their age, tobacco use, form of tobacco, frequency, and reasons for use. The data was then processed and analyzed using SPSS software.

Major Findings :

A sizeable 28 percent boys reported using some form of tobacco. The single largest proportion (23%) used *panmasala.* Other forms of tobacco were *Misri, Bidi, mava, gutkha and* cigarette. The major reasons for tobacco use were peer pressure (59%), habit (56%), constipation (23%) and fashion (20%). The main sources of tobacco products were the grocery shops (26%) and pan shops (19%). The boys were introduced to tobacco by friends (31%), parents (12%) and teachers (2%). Most boys were aware of harmful effects of tobacco (83%) and of the ban on *Gutkha* (92%) in Maharashtra. There was a significant decrease in tobacco use from class 5 (54%) to class 8 (6%).($p<0.001$)

Conclusion :

The proportion of tobacco users in this study was extremely high compared to any available data on tobacco use among school children in India. Urgent action programs are warranted to control tobacco use among school children. The action program should focus on how to resist peer pressure and avoid tobacco.

Action Plan :

Puppet shows will be conducted to depict harmful effects of tobacco and the need to stop tobacco use by students. The initial programs will be conducted in the school in which the study was conducted and gradually the program will be carried out in other schools and in communities.

Tobacco Use Among Adolescent Population

by

P B Yadav, Prakash Shikshan Prasarak Sanstha

Background :

It is a common observation that a very large number of smokers begin tobacco use before they reach adulthood. Nearly one fourth of smokers start their smoking habits before the age of 10 years. Preliminary observations in the village under study, particularly among nomadic tribes revealed high use of tobacco products. Hence it was decided to undertake a systematic study of this phenomenon in this population.

Objectives :

The primary aim of the study was to ascertain the prevalence of tobacco use, reasons for its use and the expenses of tobacco use among adolescent population of 10 -19 years in Julevadi village.

Methodology :

Using a simple random sampling technique, 200 adolescents were selected. Information on age, tobacco use, forms of tobacco, reasons for use and expenses for tobacco was collected using a pre-tested interview schedule in local language at the house of selected adolescents. The data thus obtained were processed and analyzed using SPSS.

Major Findings :

Ninety four percent of the adolescents used some form of tobacco. Chewing was the predominant form (93%). Some of them also smoked (17%). Different forms of tobacco used by the adolescents included whole tobacco (59%), *Panmasala* (16%), *Misri* (15%) and *Mava* (6%). About 38 percent started using tobacco before the age of 10 years. In most cases friends introduced them to tobacco (87%) with father and teacher contributing small proportions of 6 percent and 1 percent respectively. Common reasons for using tobacco were pleasure (41%), monotony (33%), and habit 23%. Ninety two percent spent less than five rupees per day for tobacco. Nearly 60% got money from friends.

Conclusion :

In this study 94 percent adolescents in the *Julevadi* village used tobacco. This is extremely high compared to any available data on tobacco use among adolescents. Majority of them used chewing forms of tobacco compared to smoking form. Urgent action programs are warranted to control tobacco use among this tribal population.

Action Plan:

Appropriate educational programs targeting the adolescents will be developed. These programs will include awareness on hazards of tobacco use, lectures and health talks by doctors and teachers. Materials already prepared by the national cancer control program on tobacco prevention will be the primary means of disseminating this awareness.

Tobacco Chewing Among College Students And Its Effects On Oral Health

by

Munghate Raju Govindrao, Vidyabharti Mahavidyalaya

Background :

Tobacco affects most of the organs of our body. Its impact on oral health has not been studied well in India. In Gadchiroli district many oral health problems were noted among college students who used various forms of tobacco. Therefore it was decided by the NGO to do a detailed study on the tobacco use among college students in this region.

Objectives :

The aim was

1. to ascertain the percentage of tobacco chewing among the college students,
2. the factors influencing the habit of tobacco chewing, and
3. to identify the effects of tobacco chewing on their oral health.

Methodology :

As many as 175 male college students in the age group of 19-27 years were selected using a cluster sampling procedure. Information on age, tobacco use, education of parents, tobacco use of parents and friends was collected through a pre-tested local language questionnaire. A dentist clinically examined the respondents to check their oral health problems. All data were processed and analyzed using SPSS software.

Major Findings :

Sixty two percent of the students used tobacco either occasionally or regularly. Those who had more two or more tobacco-using friends reported a higher use of tobacco (63%) compared to 49 percent use by those who had only one tobacco-using friend ($p<0.001$). Forty-five percent of tobacco users had receding gums compared to 15 percent of non-users ($p<0.001$). Also, 51 percent of tobacco users had discoloration of mucus membrane compared to 12 percent of non-users ($p<0.001$). Thickening of oral mucus membrane was present in 12 percent of tobacco users compared to 3 percent of non-users ($p<0.05$).

Conclusion :

Majority of college students in the sample used tobacco. Friends influenced tobacco use. Tobacco users had higher prevalence of oral health problems like receding gums, discoloration and thickening of mucus membrane much higher than non-users of tobacco. Urgent awareness creation of harmful effects of tobacco use is warranted among the college students in this area.

Action Plan :

Tobacco control awareness campaign will be started for all college students of the area. Also essay writing competition and poster competition to promote awareness regarding harmful effects of tobacco use among college students will be organized.

Tobacco Use Among Women In The Reproductive Age Group

By

Antaryami, Rural Development And Social Services (RDSS)

Background :

The Indian National Family Health Survey (NFHS) estimated that 35 percent of women chew tobacco in Orissa. In the Gundichapara *Panchayat* of Orissa, where this NGO is working, tobacco chewing among women is exceptionally high. Therefore, this study was undertaken in this area.

Objectives :

The primary purpose of this study was to find out the prevalence of tobacco use among women in the reproductive age group, factors associated with tobacco use among them and their awareness regarding health consequences of tobacco use.

Methodology :

Using a stratified random sampling technique, 198 women in the reproductive age group (15-45 years) were selected from Gundichapara gram Panchayat of Dhenkanal district. Information on age, forms of tobacco use, frequency, reasons for tobacco use and awareness of harmful effects of tobacco was collected from the selected women at their residence using a pre-tested interview schedule. Data processing and analysis was done using SPSS software.

Major Findings :

Tobacco use in the sample was 83.5 percent. Predominant users were chewers (60%), followed by use of tobacco paste (40%), *Panmasala* (16%), *Gutkha* (14%) and *Khaini* (13%). Over 58 percent of women in the sample started tobacco chewing before the age of 25 years. Tobacco use of 94 percent among 31-45 year age group was significantly higher than that of 64 percent in the age group of 15-20 years ($p < 0.001$). Major reasons for tobacco use were bowel movement (35%), body stimulant (29%), mouth freshener (26%) and habit (24%). Tobacco use was significantly higher among women who did not know harmful effects of tobacco (94%) compared to those who knew (64%). ($p<0.001$)

Conclusion :

Tobacco use was extremely high among women in the study area (83.5%). Tobacco use increased with age. The majority of the women were unaware of the harmful effects of tobacco and this significantly contributed to very high use of tobacco.

Action Plan :

Health education campaigns will be organized in the villages and hamlets, highlighting the health hazards of tobacco use.

OVERVIEW

Dimension / Component	Tobacco Consumption Among Boys	Tobacco Use Among Adolescents	Tobacco chewing Among College Students And Its Effects On Oral Health	Tobacco Use Among Women In Reproductive Age Group
Tobacco use in sample	Tobacco use in the sample was 28.4%	Tobacco use in the sample was 94%	Tobacco use (occasional or regular) was 62%	Tobacco use in the sample was 83.5%.
Predominant manner of use	Panmasala (23.0%) Misri (19.5%), Gutkha (8.5%), Mava (6.3%), Cigarettes (3.2%) and Bidi (1.6%).	Chewing 93%, Whole tobacco 59%, Panmasala 16%, Misri 15%, Mava 6% Smoking 17%.	Chewing was the predominant form. Data on smoking was not collected.	Chewers (60%), tobacco paste (40%), *Panmasala* (16%) *Gutkha* (14%) *Khaini* (13%)
Age started use	Tobacco use was initiated by 27.8% of boys before the age of 10 years.	Tobacco use was started by 38% of adolescents before the age of 10 years	Not collected	Over 58% of women in the sample started tobacco chewing before the age of 25 years.
Age differentials	Tobacco use was higher among boys of class 5 (54%) compared to boys of class 8 (6%) ($p<0.001$)	There was no significant difference in tobacco use among different age groups.	There was no significant difference in tobacco use among different age groups	Tobacco use of 94% among 31-45 year age group was significantly higher than that of 64% in the age group of 15-20 years ($p< 0.001$)
Major Reasons	Peer pressure (59%), Constipation 23%) Fashion (20%)	Pleasure 41%, monotony 33% habit 23%.	This was not collected	Bowel movement (35%), body stimulant (29%), mouth freshener (26%) and habit (24%).

Awareness of effects and usage	Most boys were aware of harmful effects of tobacco (83%) and about ban of Gutkha (93%).	This was not collected.	There was no difference between the literacy status of the father and tobacco use among students.	Tobacco use was significantly higher among women who did not know harmful effects of tobacco (94%) compared to those who knew (64%). ($p<0.001$)
Conclusions	Proportion of tobacco users was extremely high compared to any available data on tobacco use among school children in India.	Tobacco use was almost universal in this population. Majority of the population used nonsmoking forms of tobacco.	Majority of students in the sample used tobacco. Friends influenced tobacco use. Tobacco users had higher prevalence of oral health problems like receding gums, discoloration and thickening of mucus membrane.	Tobacco use was extremely high among women in the study area (83.5%). Tobacco use increased with age. Majority of the women were unaware of the harmful effects of tobacco and this significantly contributed to very high use of tobacco.
Action Plan	Puppet shows depicting harmful effects of tobacco and the need to stop use by students will be conducted in schools and community.	Educational programs targeting adolescents will be developed. The programs will include awareness of hazards of tobacco use.	Tobacco control awareness campaign including essay writing competition, poster competition etc will be started.	Health education campaigns will be organized in the villages and hamlets highlighting the health hazards of tobacco use.

A typical profile that emerges from the above summary of findings is that:

1. Tobacco use rises from 28 percent of respondents to over 90 percent. But there is a tendency for the adolescents to experiment before some of them drop it at a later age.

2. Tobacco use starts at a very young age of 10 years, though the females tend to start the practice at a later age, probably in the twenties.

3. Chewing tobacco is the dominant form of tobacco use.

4. While males tend to take to tobacco for 'social reasons' – company, influence and the like, females attribute their initiation to tobacco use to 'constitutional factors'.

5. At one extreme the youngest sample seemed to be more aware of the ill effects of tobacco use. At the other extreme women in the reproductive age group were much more ignorant of ill-effects.

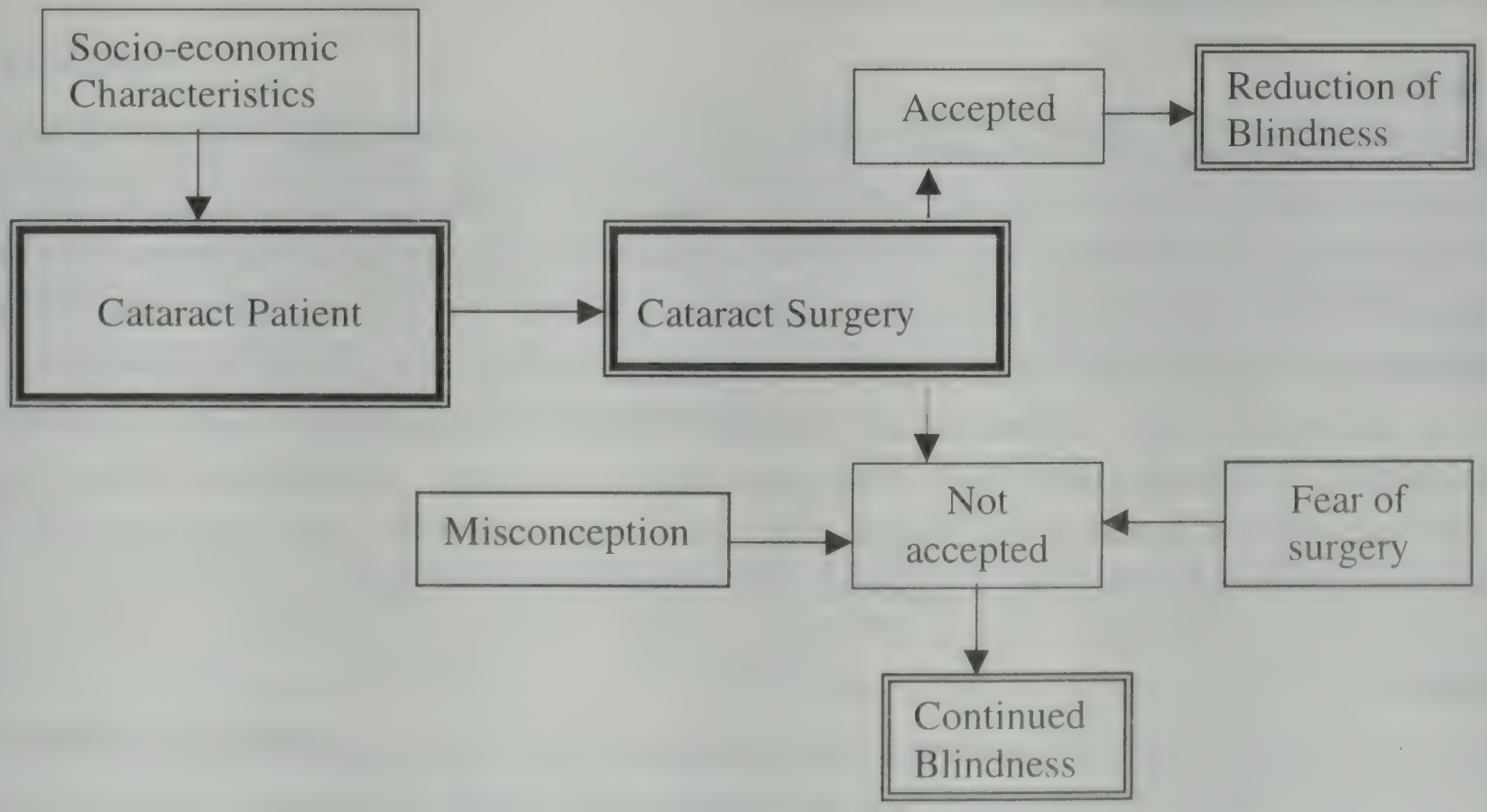
B : CATARACT SURGERY: PATIENTS PERCEPTION AND ACCEPTANCE

Introduction :

According to WHO, half the cases of blindness in the world are due to cataract. In India cataract formed 81 percent of blindness in the year 1986. It has come down to 55 percent in 1999. Cataract generally occurs in persons above the age of 50 years and the incidence increases with the advancement of age and nearly 100 percent in the age group of 80 years and older have some kind of cataract. The problem of blindness due to cataract can be prevented to a great extent through surgical intervention. The Government of India has a national control programme, which extensively propagates cataract surgeries and even provides free intra-ocular lenses. Yet there is a large number of cases who can take benefit of this national programme, are not willing to undergo cataract surgery. This could be due to misconception and fear of surgery in the eye. The present study would like to bring out these factors, which will contribute to the implementation of the government programme for cataract patients.

Conceptual Framework :

Keeping in mind the above, two studies have been done on those who have cataract. The specific aim of



these studies is to find out the characteristics of patients needing surgical treatment for cataract, and to study the factors determining acceptance of surgical treatment for cataract.

The abstracts of the reports on these studies are now presented.

Factors Determining Acceptance Of Surgical Treatment For Cataract

By

Swati A. Dixit, Mohan Thuse Netra Rugnalaya

Background:

Mohan Thuse Netra Rugnalaya, for several years, has been providing eye care through its Base Hospital and Community Eye Care Services, in the rural areas of Junnar Taluka of Pune District. It has been observed that, despite the availability and access to good quality eye care services, several patients do not take the benefits. The present study explored the reasons for acceptance as well as non-acceptance of the eye care services provided through the Organization.

Objective:

The objective of the study was to study the factors determining the acceptance / non-acceptance of the surgical treatment for cataract.

Methodology :

The study was conducted in 8 villages of Junnar Taluka of Pune district with a population of 16,845. All people of the age 40 years or more were screened for cataract. A pre-tested interview schedule was canvassed with those people who had undergone surgery for cataract, and a separate schedule was applied for those who had not accepted surgery for cataract.

Major Findings :

Of a total of 411 people who were screened, 186 (45.2%) had cataract. Of these, 65 (35%) had accepted surgical treatment and 121 (65%) had not. While sex, education, family type and family income were not significant factors that determined acceptance / non-acceptance, knowledge about cataract and its symptoms were significantly more among those who had accepted surgical treatment. A high 65 percent of the people who had accepted surgical treatment obtained the knowledge through eye camps, and were motivated to do so by the doctors. But then, 48 percent of the people who had not accepted surgical treatment were those who had been recently diagnosed / diagnosed during the study, or had been informed that their cataract was not mature, and actually do not reflect true non-acceptance. The major reasons for non-acceptance were fear (11%), lack of a chaperone (6.7%) and high costs (6%).

Conclusion :

Eye Camps are useful in diagnosing cataract and informing people about surgical treatment. Myths about maturity and costs need to be dispelled, and the Organization needs to motivate volunteers to act as chaperones.

Action Plan :

The Organization plans to intensify its Community Eye Health Programmes, and provide further information to people about cataract and its surgical treatment.

Factors Determining Acceptance Of Cataract Surgery By Women

By

Dhirendra Kumar Mohanty, National Youth Service Action and Social Development Research Institute (NYSASDRI)

Background :

Of the 996 Cataract Surgeries performed through the project of NYSASDRI during the period April 1998 to March 2002, only 37 percent were women. NYSASDRI explored the reasons for acceptance / non-acceptance of cataract surgery by women in the present study.

Objective :

The objective was to study factors determining acceptance / non-acceptance of cataract surgery by women in Gondia Block of Dhenkanal District of Orissa.

Methodology :

During the period under study, 52 screening camps organized by NYSASDRI recommended 728 patients for cataract surgery. Of the 365 women, only 195 (53%) got themselves operated, as compared to 65 percent men getting themselves operated upon. A random sample of 53 women operated upon and 47 not operated upon were interviewed from the 50 villages of NYSASDRI's Project Area of Gondia block, Dhenkanal district, Orissa.

Major Findings :

Age of the patients, family type and income, literacy and caste were not significant in determining acceptance / non-acceptance. Knowledge about cataract and its symptoms was also not significantly different between the two groups. The major reasons for acceptance of cataract surgery was the information gained about free treatment from relatives / friends, and the willingness to regain proper eyesight. The major reasons for non-acceptance were the lack of attendants, lack of time, hesitation to disturb the family members and lack of conviction of the benefits of surgical interventions.

Conclusion :

NYSASDRI has succeeded in creating awareness about cataract, its symptoms and treatment through surgery. However, acceptance of cataract surgery by women is poor mainly due to social reasons like domestic responsibilities, and dependence upon attendants. Another important reason is a doubt about the benefits of cataract surgery.

Action Plan :

NYSASDRI plans to continue its eye camp and screening approach. Patients recommended for cataract surgery will be followed up for acceptance / non-acceptance, and in case of the latter, family members, too, will be counseled about the benefits of surgery and the need to spare some time for the benefit of the patient.

OVERVIEW

Eye Camps are useful in diagnosing cataract and informing people about surgical treatment. Volunteers need to be motivated to act as chaperones.

However, acceptance of cataract surgery by women is poor mainly due to social reasons like domestic responsibilities, and dependence upon attendants. Another important reason is a doubt about the benefits of cataract surgery.

Section III : Profiles of NGOs

NGO Profiles

	Organisation	Description
1.	Centre for Regional Education, Forest and Tourism Development Agency (CREFTDA), Post : Jashipur, Mayurbhanj, Dist. Orissa - 757 034	CREFTDA is an NGO established in 1992 working in the foothills of the National Forest Park, Simlipal, Orissa. The community covered is the scheduled tribe and scheduled caste who cover 70% of the district population. The activities of the organization include health action research, empowerment of the people, sustainable agriculture, development of economic measures for the poor and institutional building.
2.	Citizens' Association for Rural Development (CARD), At : Corporation Road, Berhampur, Dist. Ganjam, Orissa - 760 001	CARD is a NGO established in 1991 and works for development and promotion of tribal areas and economically weaker sections of people in Ganjam district of Orissa.
3.	Committed Community Development Trust (CCDT), R. No.8 Ground Floor Pali Chimbai Municipal School St. Joseph Road, Chimbai, Bandra (W), Mumbai - 400 050	CCDT was founded in June 1990. It is located in Mumbai, Maharashtra and its mission is to provide marginalized communities with social relevance through comprehensive programs of development, integrating health services, social education and community development using a participatory approach. CCDT works on several people-oriented development projects with communities who are often discriminated on the basis of their occupation, disease and socio-economic conditions. CCDT's thrust areas are community and reproductive health, HIV / AIDS and children in specially difficult situations. It works with professional staff and health volunteers who assist in providing direct services to the service users including People Living with HIV/AIDS (PLHA).
4.	Community Development Centre (CDC) Post Box 17, Balaghat Madhya, Pradesh - 481 001	The Centre is an NGO based in Balaghat district of Madhya Pradesh. It has been working since 10 years among the tribal community in both Balaghat and Seoni districts. The main activities are awareness creation about health, health education, strengthening of local self-governance, environment awareness and capacity building of small NGOs and CBO's through training.
5.	Dr. Sali Medical Foundation, Manchar, Dist. Pune - 410 503. Maharashtra	Sali Medical Foundation was established in 1994 at 'Manchar', a small town located in Ambegaon Taluka near Pune, with an aim to uplift the health status of rural and tribal women and children in 166 villages, of which 58 are tribal and 52 are draught-prone. It runs a hospital and provides medical and surgical treatment to the poor people either free or at a concession by arranging regular health camps at distant villages, family planning services, cancer detection and treatment, health education. It also conducts training programmes for doctors, nurses, midwives, teachers etc.
6.	Friends Puppet Theatre, E-11, Shweta Society Jaydeonagar, Sinhagad, Pune - 30	Friends Puppets Theatre is an NGO formed in 1992 by a group of young women and works with the media of puppetry for social awareness on various issues. The organization has conducted nearly 10,000 puppet shows on various topics like personal hygiene, environment, importance of educating girl child, women empowerment, consumer awareness, addiction, watershed development, health and nutrition and self help groups. Apart from puppetry shows, the organization also undertakes several projects on national environmental awareness.

7.	Health & Hope Project, GM Priya Hospital, Dapegaon, TQ Ausa Latur, Dist - 413 572	Health and Hope project is one of the projects of Emmanuel Hospital Association (Delhi) and is based at G. M. Priya hospital in Dapegaon, Latur district of Maharashtra. The organization undertakes community health work in 32 villages covering a population of 44,000. Presently work is going on in the area of women empowerment model for HIV/AIDS prevention and care.
8.	Janaseva Foundation Indulal Complex, Lal Bahadur Shastri Marg, Pune, Maharashtra - 411 030	The Foundation is an NGO, based in Pune and working in the Panshet Block of Pune District. The Organization has a 35-bedded Rural Hospital, an Old Age Home for 140 Inmates, and a Paralysis Rehabilitation Center. Self Help Groups are promoted in the villages around Panshet. The Organization conducts regular School Health Education Programmes and Check Ups in 40 Schools of the Block.
9.	Kushtharog Niwaran Samiti Shantivan Nere, Panvel 410 206	The organization has been working in Panvel taluka for around the last 50 years in the field of leprosy. WHO and Government of India have allotted them the Panvel Taluka that comprises 185 villages and urban area for eradication of leprosy. The population covered is 3.5 lakhs and the organization runs 8 SET Centres, 1 Urban Leprosy Unit and 34 Drug distribution centres today.
10.	Maitree Yuva Sansad, At. Maitri Sarani Po. Nayagarh Bazar, Orissa - 752 070	Maitree is an NGO that came into existence in 1990 and is associated with an educated and committed youth mass. Its major thrust areas are promotion of health, education and environment as well as empowerment of women. Various developmental activities are being conducted in Nayagarh and Nuagaon blocks of Nayagarh District, which include reproductive and child health, promoting adolescent health education in educational set-up, free health checkup camps, water and sanitation activities, conducting animal health checkup camps, organizing a child labour school, running a training cum production center of leaflets for the women, running self help groups etc.
11.	March of Youth for Health, Education and Action for Rural Trust (MY-HEART), RP-115, Pandaba Nagar, Tankapani Road Bhubaneshwar, Orissa - 751 018	MY HEART is an NGO implementing RCH programme sponsored by the Ministry of Health and Family Welfare in five tribal dominated districts of Orissa.
12.	Mohan Thuse Netra Rugnalaya, Narayangaon, Taluka Junnar, Pune Dist. Maharashtra - 410 504	Mohan Thuse was founded in 1982 at Narayangaon in Junnar Taluka, Pune District of Maharashtra. The hospital has been treating patients for the last 21 years with 15 eye surgeons from Pune city rendering honorary services. The area catered to covers three districts of Pune, Ahmednagar, and Thane, with 8 Talukas and over 22 lakh population. The main aim of the organization is to eradicate blindness of people, make them independent and reduce the burden on society. The various activities carried out by the organization include Intraocular Lens Implantation (IOL) surgeries, VITRO Retinal surgery, free eye check-up camps within the radius of 150 Km, free of charge treatment for needy people, facilities like free-of-charge food, transport, medicines, stay and spectacles, free examinations in schools, eye care awareness camps and video shows regarding eye care.
13.	Nagarik Arogya Rakshaka Sanstha, Desaiganj Tq, Desaiganj Dist, Gadchiroli, Maharashrra	Nagrik is an NGO established in 1996 with the mission of protecting and providing good health to rural people. The area of operation is in the tribal and backward district of Gadchiroli in Maharashtra. The organizations focuses on different issues like empowerment of women, establishment of self help groups, Vanaushadhi Prashikshan (Herbal Medicines Plants Training) and environmental programmes. The organization has arranged about 60 diagnostic camps in tribal and remote areas in the last 3 years for heart patients, reproductive health problems, cancer, eye care etc. A charitable clinic is also run by the organization.

14.	National Youth Service Action and Social Development Research Institute (NYSASDRI), Friends' Colony, Bajrakavidi Road, Cuttack, Orissa	NYSASDRI is an NGO based in the Dhenkanal district of Orissa since 1973. It covers 7 districts in 500 villages and works in the areas of rural development, health and literacy. It also has a 20-bedded eye hospital through which eye care services are provided in 8 blocks of Dhenkanal district.
15.	Orissa Institute of Medical Research and Health Services (OMRAH) Friends' Colony, Bajrakauidi Road, Cuttack, Orissa	OMRAH, is an NGO working in the field of community health in Cuttack, Orissa for more than a decade. It focuses mainly on reproductive and child health issues, especially pertaining to sexual and reproductive health problems of adolescent girls.
16.	Pallishree, Narasinghpur P. O. Nahanga Patana Via Dharmasala, Dist. Jajpur - 755 008, Orissa	Pallishree is a voluntary organization formed in 1987. It is located in Jajpur district of Orissa and works in 128 villages covering 21 Gram panchayats in 6 Block areas in Jajpur. The activities of the organization include livelihood promotion, environmental protection and community health amongst the poor and vulnerable in the area. The specific health issues targeted are basic health awareness and RCH.
17.	People's Educational Action and Communal Evocation (PEACE), At & Post : Mohana, Dist. Gajapati, Orissa - 761 015	PEACE is an NGO working since 1994 in the Mohana Block of Gajapati district in Orissa for the socio-economic development of tribals in the area. It also initiates and implements projects for the economic development of women, strengthening of immunisation programme, Indian system of medicine, homeopathy etc.
18.	Pragati, Post Box No. 34, New Colony Rayagada - 765 001. Orissa	Pragati was started in 1994 in the district of Rayagada and works in six Gram Panchayats (G.Ps) of Rayagada Block and one Gram Panchayat (G.P) of K.Singpur Block It is committed to rural development in the field of education, health and socio-economic development of the rural poor.
19.	Prakash Shikshan Prasarak Sanstha, (PSPS) Tasgaon, Sangli Dist, Maharashtra - 416 312	Prakash Shikshan is an NGO established in 1985 to assist women in earning some money by training them in courses like tailoring, crafts and balwadi courses. Its activities are concentrated in the Tasgaon Tehsil of Sangli District in Maharashtra. Although the main focus is on rural women, it has also undertaken various activities for youth, AIDS patients, old persons and most importantly, children. It is now working in 10 villages of the Tasgaon tehsil focussing on the development of the women and children belonging to the nomadic tribes of Nandiwale and the Gosawi.
20.	Ramkrishna Mission Ashrama, (RKM) Vivekananda Arogya Dham, Sector 15 B, Madhya Marg, Chandigarh - 160 015	Ramakrishna Mission Ashrama in Narainpur was started as a sub-centre of the Ramakrishna Mission, Vivekananda Ashrama, Raipur in 1985. It became an independent Centre of the Ramakrishna Math and the Ramakrishna Mission, Belur Math in 1990. Since its inception, the Mission is engaged in improving the literacy, health and socio-economic status of the Halba, Gond, Muria and Maria tribes of the Bastar district of Chattisgarh state. It has a 30-bedded well-equipped hospital Vivekananda Arogya Dham with modern equipment. It also runs a mobile dispensary 'Vivekananda-Chal-Chikitsalaya for poor patients from about 100 far off villages, who are treated free of charge. The Mission also manages five Health Posts.

21.	Rashikashraya Sanskrutik Kala & Bahuuddesiya Sanstha, Gurudev Ward, Ghatanji, Tq. Ghatanji, Dist. Yavatmal - 445301. Maharashtra	Rasikashraya is an NGO founded in 1999 by a group of youth committed to the cause of development and community empowerment of rural poor. Crucial issues with social, economical and cultural perception are dealt with the active participation of people in self-governing organizations such as youth groups, women's self-help groups, adolescent groups and farmer study groups. Activities carried out include Adolescent Skill development programme, Child Development programme, Rural Creches / Units, Youth Development Programme, Women Awareness Generation Programme etc.
22.	Rural Development and Social Services (RDSS), At Paschima Kachha, P.O. Madhya Kachha Via Bahugram - 754200 Dist. Cuttak, Orissa	RDSS evolved in 1994, from a youth group's voluntary action in a rural pocket on the bank of the River Mahanadi. RDSS is involved in socio-developmental actions in 4 Gram Panchayats (Block Salipur District, Cuttack). Children, young men and women are the focus group on the fronts of formal, non-formal education and acquisition and upgradation of vocational skills. It also undertakes health action and education drives either on its own or jointly with Orissa Voluntary Health Association (OVHA) of which it is a constituent.
23.	Service Activities for Human Affairs with Youth Action (SAHAYA), At. Panchumu, P.O. Bhaliadihi Via Godipada, Nayagarh Orissa - 752 092	SAHAYA is an NGO started in 1996 and working with the rural and tribal villages covering 70 villages in remote areas of Nayagarh district comprising 3 blocks. The total population of the area is 22,000 of which 75 percent are from rural and tribal areas. The organization is involved in the upliftment of rural community and undertakes awareness generation and other developmental activities for the rural population, particularly for women and child health. Village committees consisting of men, women and youth are formed and actively involved in planning and implementation of development programmes by mobilizing their own resources.
24.	Service for Health and Rural Education (SHARE), Redburn Main, Landour, Mussorie, Dehradun, Uttaranchal - 248 179 Uttar Pradesh	SHARE is an NGO started with the aim of making "Health for All" a reality for the people living in the Himalayas. The organization is a unit of the Emmanuel Hospital Association (Delhi) and is based in Mussoorie, working among the Garhwali people of Jaunpur block of Tehri Garhwal district. The goal of SHARE is to improve the health status of the people staying in the project area through development of health systems and a process of social and economic change. Towards this end, SHARE has been involved in conducting village clinics, training Community Health Volunteers and traditional birth attendants and health education.
25.	Social Education and Reconstruction of Village Environment (SERVE), Palace Road, Parlakhemundi, Dist. Gajapati, Orissa - 761200	SERVE is an NGO working in the ST / SC villages of Kashinagar Block, Gajapati District, Orissa State. The main target group for development is the Saura Tribe, which are a very primitive and backward tribe. In addition, the organization is also working in another 6 Gram Panchayats for integrated development. The organization has implemented many programs for socio-economic, health, education and environmental awareness and development, with the help of concerned department's functionaries of Panchayat Raj institutions and community leaders.
26.	Social Education for Women's Awareness (SEWA). At : Baunsuni, Maulimunda Street, Dist. Boudh, Orissa - 762 015.	SEWA, is an NGO established in 1991 based in the Jharsguda district of Orissa. The NGO works among the rural poor and its activities include community health, promotion of literacy, information dissemination , reducing women's dowry and childhood malnutrition

27.	Society for HIV, AIDS and Lifeline Operation in Manipur (SHALOM), P.O. Box 139 Nehru Marg, Churachandpur, Manipur - 795 128	SHALOM is a community health organization established in 1995 with technical assistance from the Emmanuel Hospital Association (Delhi). It seeks to provide comprehensive HIV Prevention and AIDS care to meet the needs of a community deeply affected by HIV in Churachandpur District of Manipur. Initially, SHALOM focused on community education and health promotion, sexual health with vocational rehabilitation of female IDUs, CSWs, & HIV affected women, home-based care for PLWHAs with HIV Testing and injecting drug users services. In addition it now has a 10-bedded Hospice and has also added TB Treatment and control programme to its activities.
28.	Society for People's Awareness and Rural Development Action (SPARDA), Baruni Road, Ward No. 7, Baripada, Mayurbhanj, Orissa - 757001	SPARDA is a grassroot NGO, established in the year 1990 by a group of committed young persons in Mayurbhanj district. It is also registered under the Foreign Contribution Regulation Act. The main philosophy of SPARDA is oriented towards sustainable development of the rural people through health, education, environment and economic upliftment, with conservation of non-renewable natural resources, application of indigenous science technological innovations and judicious use of governmental resources for larger benefit of the poor and suppressed people, especially the women and tribes of Mayurbhanj district. In the area of health the organisation is working on Malaria, RCH and TB in 33 villages of 5 Grampanchayats of Udala Block, Suliapada Block and Kuliana Block respectively and covers the total population of 21,471. Similarly in the area of environment the organization is working on community forest and joint forest management and biodiversity conservation with 316 village forest committees under 9 CD Blocks of Mayurbhanj district.
29.	The Duncan Hospital, P.O. Raxaul, East Champaran, Bihar - 845 305	The Duncan Hospital in Raxaul, Bihar is a member of the Emmanuel Hospital Association (Delhi) since 1974. It is a 175-bedded hospital situated in East Champaran district of Bihar, which is very close to the Indo Nepal border. Approximately one third of the patients coming to the hospital are from Nepal. The region from where patients come is extremely backward and underdeveloped. The Duncan Hospital has two Community Health Projects CHAMPAK and CHETNA and is committed to the transformation of communities with programmes that invest in the health and well being of every one.
30.	The Leprosy Mission Purulia Leprosy Mission Hospital, Dist. Purulia, West Bengal - 723 101	The Leprosy Mission is an international NGO working in co-operation with National Leprosy Eradication Programme (NLEP). Since 1888, it has been running a Home and 150-bedded Hospital just outside Purulia town, providing a comprehensive range of services for leprosy affected patients.
31.	Tushar Community Health Education and Development project, Manduwala Premnagar, Uttaranchal 248 007. Uttar Pradesh	Tushar is a unit of the Emmanuel Hospital Association (Delhi) and has been working in the villages of Sahaspur Block of Dehradun district for the last 16 years. 49 villages are covered in this project with a population of about 25,000 people, mainly Hindu and Muslim subsistence farmers. The issues taken up pertain to health education, literacy and self-help groups.
32.	Universal Service Organisation (USO), Basuguda Road, At. B. Devadala Po Komotalpeta, Dist. Rayagada, Orissa - 765 017	USO is a development organisation initiated in 1980 with intervention programme on drought mitigation in Danagadi Block of present Jajpur District in Orissa. From 1993 onwards, the organization is actively involved in the field of self-help action among women, health, handicraft and natural resource development in 14 Gram Panchayats of Kolonara, Rayagada and Kashipur blocks of Rayagada district in Orissa. Since the last 5 years it has focused on women's empowerment, micro credit and micro enterprise among tribal women and reproductive and child health.

33.	Utkal Sevak Samaj (USS) Plot No. 191, Mohanadi Vihar, Post Nayabazar, Dist. Cuttack, Orissa - 753 004	USS, is one of the leading NGOs of Orissa and is working for the last 15 years for the development of poor community. It was started in 1989 in a rural pocket in Cuttack district. Its mission is "working for participatory sustainable community development of the poor and marginalized (including tribals, dalits, and women) and joining them in their struggle for their rights of a social constituent, a citizen and human being." In this perspective, the organization has been working in the field of health, education, income generation, agriculture, civil education and empowerment and has implemented various developmental programmes.
34.	Vidyabharti Mahavidyalavya, Kurkheda, Dist. Gadchiroli, Maharashtra - 441 209	Vidyabharti, Kurkheda is an NGO of higher education, working in the most backward tribal area of Gadchiroli district of Maharastra. The institute is run by Dandakaranya Educational, Cultural and Social Development Society, Gadchiroli, which is one of the leading organizations working for the socio-educational development of the tribal community of the area. Additionally, the organization is also conducting various programs and projects related to socio-cultural and medical research for the betterment of the local tribal peoples. Along with the provision of higher education, creating awareness about environment and health among the tribal students is the main activity of the institute. This includes programmes such as National Environment Awareness Campaign, Water literacy Programme, Health Research Project, Adult Literacy Programme, Child Science Congress, District Co-ordinating Center and Computer Literacy Programme For Tribal Youth.
35.	Youth Council for Development Alternatives (YCDA), At : Baunsuni, Maulimunda Street, Dist. Boudh, Orissa - 762 015	The organization is an NGO established in 1993, working in 9 gram panchayats of Boudh district in Orissa. The community covered is the rural poor and the activities include youth development, community organization, livelihood issues, rights of children as well as community health issues such as behaviour change communication, traditional health care practices, formation of village health committees and establishment of village level drug delivery centres. It also works for the rehabilitation of cyclone affected people in Cuttack District.
36.	Yuvagram Vikas Mandal, Kaij, Dharur Road, Dist. Beed, Maharashtra - 431 123	Yuvagram is a voluntary organization founded in 1985 by a group of youth committed to the cause of development of women, children and youth. They first started with awareness and rehabilitation works for the village, which was affected due to construction of a dam on a local river. Later they started community development programmes such as rehabilitation and resettlement, safe drinking water, hygiene and sanitation programme (in 13 villages of Beed district), watershed development programme, community-based rehabilitation for the disabled, reproductive child health programme, dairy development for the destitute and widows, a network on child sex abuse and to combat human trafficking.